United States Court of Appeals

for the Second Circuit

APPENDIX

75-6128

United States Court of Appeals

FOR THE SECOND CIRCUIT

B

P/S

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs-Appellants,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs-Appellants,

—against—

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants-Respondents.

UNITED STATES COURT OF APPEALS
FILED
JAN 9 1976
A. DANIEL FUSARO, CLERK
SECOND CIRCUIT

JOINT APPENDIX

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J

PAGINATION AS IN ORIGINAL COPY

INDEX TO APPENDIX

	PAGE
Docket Entries	1a
Summons	2a
Complaint	3a
Exhibit 1—Part A Intermediary Letter No. 75-58, Dated October 1975	15a
Order to Show Cause With Temporary Restraining Order	19a
Affidavit of Philip C. Abrams in Support of Application	22a
Affidavit of Joseph L. Bloch in Support of Application	25a
Affidavit of Kenneth F. Adamec in Support of Application	34a
Affidavit of Irwin M. Birnbaum in Support of Application	38a
Certification of Notice of Susan Rosenfeld	44a
Transcript of Proceedings	45a

PAGE

WITNESSES FOR PLAINTIFFS:

James C. Ingram
Direct 54a
Cross 75a
Redirect 97a
Recalled
Redirect 189a

Irwin B[illegible]aum
[illegible] 102a
[illegible] 122a
[illegible] 134a
[illegible] 135a

Philip C. Abrams
Direct 141a
[illegible] 154a
[illegible] 158a
[illegible] 159a

[illegible]
[illegible] 167a
Cross 174a
Redirect 175a

Peter B. Terenzio
Direct 176a
Cross 183a

PAGE

WITNESS FOR DEFENDANTS:

John W. Jansak
Direct 193a
Cross 226a
Redirect 263a
Recross 272a

PLAINTIFFS' EXHIBITS:

1—Schedule of PIP Payments 279a

2—Intermediary Letter No. 75-58, Dated October 1975 ..... 282a
40 Fed. Reg. 40192-40193, Dated 9/2/75 ..... 286a
40 Fed. Reg. 29815-29817, Dated 7/16/75 ..... 288a
39 Fed. Reg. 2011-2012, Dated 1/16/74 ..... 291a
Intermediary Letter 73-37, Dated February 1973 .. 293a
Intermediary Letter 73-24, Dated June 1973 ..... 297a

Opinion and Order of Judge Metzner Permitting Intervention 301a

Order to Show Cause of Intervenor Plaintiffs 302a

Affidavit of Andrew Ross in Support of Application for Intervention 305a

Certification of Andrew Ross in Support of Application for Intervention 308a

PAGE

Proposed Complaint in Support of Application for Intervention 309a

Opinion and Order of Judge Metzner Dismissing Complaint 311a

Order Granting Stay of Judgment 323a

Plaintiffs' Notice of Appeal 325a

Plaintiffs' Bond for Costs on Appeal 327a

Notice of Appeal of Intervenor Plaintiffs 328a

Stipulation Designating Exhibits 330a

Docket Entries

75 Civ 5902 ... METZNER, J.

DATE	NR.	PROCEEDINGS
11-21-75	1	Filed complaint and issued summons.
11-21-75	2	Filed pltfs. affdt. and OSC--ORDERED that defts. show cause on Nov. 28,1975 at 10am in Rm.2703 why an order should not be entered granting pltfs. prel.injunction,etc; Metzner,J.
11-25-75	3	Filed memorandum of law in support of plaintiffs' motion for a prel. inj.
11-25-75	4	Filed summons and affdvt. of service by certified mail to: Mr. St. John Barrett Axting General Counsel of Department of H.E.& W., Wash., DC. David Matthews, Sec. to the US Dept. of H.E.& W., Wash., D.C. James B. Cardwell, Comm. of Social Security Adm., Baltimore, Maryland Atty. Gen'l Dept. of Justice, Wash., D.C.
12-04-75	5	Filed opinion #43472 that the application for intervention in the action on behalf of those plaintiffs set forth in the proposed complaint is granted. The determination of the motion for prel. inj. in which evidence was taken on 11-28-75 will be binding on the intervenors without further evidence being adduced. I will assume that the pattern as developed on the evidentiary hearing concerning the original plaintiffs would be the same for the intervenors if proof was submitted on their behalf. So ordered. m.n. (unsigned O.S.C. is attached hereto.)
12-05-75	6	Filed plaintiffs' post hearing memorandum
12-08-75	7	Filed defendants affdvt. of Frederick P. Schaeffer in opposition to pltfs motion for prel. injunction.
12-08-75	8	Filed defendants memorandum in opposition to pltfs motion for prel. injunction.
11-28-75		Hearing on OSC begun for a prel. injunction and concluded. Decision reserved.
12-11-75	9	Filed copy of record of proceedings dated 11-18-75
12-11-75	10	Filed defendants' memorandum of law in opposition to pltfs' motion for a preliminary injunction.
12-11-75	11	Filed OPINION #43521..After the close of of the evidentiary hearing held on the motion, 25 other voluntary non-profit hospitals applied for and were granted permission to intervene in the proceedings. All parties consent to advancing the trial of the action on the merits and consolidating it with the hearing of the application. For reasons stated herein, THE COMPLAINT IS DISMISSED. So ordered. -- Metzner, m.n.
12-12-75	12	Filed by pltfs Greater New York Hospital Association and Peninsula Hospital Center notice of appeal to the USCA for the 2nd Circuit from order and judgment dismissing complaint. - copies mailed to: US Attorney and Hayt Hayt Tolmach & Landau, Esqs.
2-15-75	13	Filed order granting stay of judgment and ordered that until 12-23-75 defendants are stayed as indicated herein. -- Metzner, J.
12-17-75	14	Filed letter by Proskauer Rose Goetz & Mendelsohn dated 12-9-75 to Judge Metzner re copy of defendants supplemental memorandum, etc.
12-17-75	15	Filed Bond - Undertaking cost on appeal -- $250.00 - Aetna Casualty and Surety Co.

12/22/75

JAMES M. MCGRATH, Clerk

By _____
Deputy Clerk

Summons

United States District Court

FOR THE

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION FILE NO. 75 Civ. 5902

JUDGE Metzner

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs

v.

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants

SUMMONS

To the above named Defendant :

You are hereby summoned and required to serve upon Proskauer Rose Goetz & Mendelsohn

plaintiffs attorney , whose address is 300 Park Avenue, New York, New York 10022

an answer to the complaint which is herewith served upon you, within ~~20~~ 60 days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

RAYMOND F. Burghardt
Clerk of Court.

G. Harbison
Deputy Clerk.

Date: November 21, 1975

[Seal of Court]

NOTE:—This summons is issued pursuant to Rule 4 of the Federal Rules of Civil Procedure.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,	CLASS ACTION COMPLAINT
Plaintiffs,	
- against -	
DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,	
Defendants.	

CLASS ACTION COMPLAINT

Plaintiffs by their attorney, Proskauer Rose Goetz & Mendelsohn, for their complaint herein respectfully allege:

I. PRELIMINARY STATEMENT

1. This is a class action for preliminary and permanent injunctive relief and a declaratory judgment brought by Greater New York Hospital Association (GNYHA) a nonprofit association, and Peninsula Hospital Center (Peninsula) a voluntary teaching hospital and member of GNYHA, on behalf of themselves and the Association's members which are voluntary hospitals in the greater New York area currently being reimbursed for services rendered to Medicare Patients under the Periodic Interim Payments method estab-

lished in 1968. Under this method ("Old PIP") hospitals are paid for Medicare services approximately 3 days after they are rendered. The Class is comprised of those members of GNYHA which are being reimbursed under the Old PIP method.

2. The defendants herein, the Secretary of Health, Education and Welfare (HEW), and the Commissioner of Social Security have promulgated a regulation (the "regulation"), 40 F.R. 29815, which changes the Old PIP method so that instead of the present average three day lag existing between the delivery of services by these hospitals and payment therefor by HEW, there will be a three week lag ("New PIP method"). The regulation as originally published on July 16, 1975 required hospitals being paid under the Old PIP method to convert to New PIP by September 15, 1975. On September 2, 1975, the HEW extended to May 31, 1976 the date by which the final conversion from Old PIP to New PIP was to be effected. The first step in the conversion will take place on December 1, 1975 when HEW will withhold from the Class the weekly payment then due under Old PIP.

3. In October, 1975, the procedure by which the conversion from Old PIP to New PIP was to be accomplished was announced (Part A Intermediary Letter 75-58). A copy of this intermediary letter is annexed hereto as Exhibit 1. Under this procedure, all hospitals being paid under Old PIP will have their December 1 Medicare payments withheld and deductions will be taken from their subsequent payments in amounts sufficient to institute the three week lag by May 31, 1976. This procedure will permanently deprive these hospitals of over $12 million of cash flow on December 1, 1975 and of over $35 million of cash flow by May 31, 1976.

4. Defendants have no valid reason for requiring the conversion from Old PIP to New PIP and are doing so only for the purpose of decreasing HEW's Medicare reimbursement payments. The actions of defendants in promulgating the regulation and applying it to the Class are in violation of the Medicare Act, 42 USC §1395 et seq., the regulations enacted pursuant thereto, the Administrative Procedure Act, 5 U.S.C. §701 et seq. and the Fifth Amendment to the United States Constitution.

JURISDICTION AND VENUE

5. This action arises under the Medicare Act, 42 USC §1395, et seq. the Administrative Procedure Act, 5 U.S.C. §701 et seq. and the Fifth Amendment to the United States Constitution. Jurisdiction is vested in this Court under 28 USC §1331; 28 USC §1361 and 28 USC §2201. The amount in controversy exceeds the sum of Ten Thousand ($10,000) Dollars exclusive of interest and costs.

Venue lies in this District pursuant to 28 USC §1391.

PLAINTIFFS

6. Plaintiff Greater New York Hospital Association ("GNYHA") is a non-profit unincorporated association having its principal place of business at 3 East 54 Street, New York, New York and organized for the purpose of providing administrative and legal assistance to voluntary and government hospitals in the greater New York area (New York City and the Counties of Nassau, Suffolk and Westchester in the State of New York). GNYHA is comprised of voluntary non-

profit hospitals, municipal hospitals and voluntary non-profit long-term care facilities in the greater New York area. One of GNYHA's principal concerns is the financial viability of its members. Approximately fifty-six of its members are currently being reimbursed under the Old PIP method. Plaintiff Peninsula is a voluntary non-profit teaching hospital located in Far Rockaway, New York. Peninsula is a member of GNYHA and is being reimbursed by HEW under the Old PIP method.

DEFENDANTS

7. Defendant David Matthews or his predecessor in office was and still is the Secretary and/or Acting Secretary of the United States Department of Health, Education and Welfare and is sued in his official capacity. Defendant James B. Cardwell or his predecessor in office was and still is the Commissioner and/or Acting Commissioner of Social Security of the United States Department of Health, Education and Welfare and is sued in his official capacity. The Secretary of HEW and the Commissioner of Social Security are responsible for the administration of the Medicare program. Defendants are required to administer the Medicare program in accordance with the Medicare Act and regulations, the United States Constitution and other applicable laws and regulations.

CLASS ACTION ALLEGATIONS

8. Plaintiffs are authorized to and do bring this action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure on behalf of themselves and all of the

Association's members who are presently being reimbursed under the Old PIP reimbursement method. The Class is so numerous that joinder of all members is impracticable. There are questions of law and fact common to the Class, including whether defendants' proposed action is in violation of the Medicare Act and regulations, the Fifth Amendment of the United States Constitution and the Administrative Procedure Act. Plaintiffs' claims are typical of the claims of the Class. Plaintiffs will fairly and adequately protect the interests of the Class. Defendants have acted and refused to act on grounds generally applicable to the Class, thereby making appropriate final injunctive and declaratory relief with respect to the Class as a whole.

STATEMENT OF FACTS

9. In 1965, Congress enacted the Medicare Act, 42 USC §1395 et seq. which established a health insurance program for persons age 65 and older. Under the terms of this law, hospitals and other providers are reimbursed for the reasonable cost of services rendered to individuals covered under the program. Hospital reimbursement is not calculated on the basis of individual bills to Medicare patients. Rather, total allowable hospital costs are aggregated on an annual basis and then by a sophisticated accounting system the percentage of these costs which can be ascribed to services rendered to Medicare beneficiaries is determined. Although the final calculation and adjustment of payments for Medicare costs is made at the end of the fiscal year, payments based on estimated costs are made to the hospitals throughout the year.

10. Prior to 1968, HEW conditioned the payment of these interim reimbursements on the receipt of individual patient bills. As a result of this policy, there was often a considerable delay between the time that a hospital rendered services to a Medicare beneficiary and the time that it received payment therefor. This made it quite difficult for hospitals, particularly those in the large urban areas which have large emergency room and out-patient deficits, to meet their current cash requirements.

11. In order to remedy this situation, in 1968 HEW offered the hospitals an alternate system of payment under which interim payments would be separated from the processing of final invoices. Hospitals electing reimbursement under this method of "Periodic Interim Payments" ("Old PIP") would receive 1/52nd of their estimated annual cost of Medicare services each week, regardless of the number of bills they submitted. Hospitals were still required to submit bills promptly which were subject to final audit and adjustment, but not as a prerequisite to interim reimbursement. Most hospitals in the greater New York area elected the Old PIP payment system.

12. On January 29, 1973, the Secretary, without any explanation, announced that until July 1, 1973 hospitals would no longer be able to elect payment under Old PIP. This change in policy did not affect hospitals already being paid under Old PIP.

13. In June, 1973, hospitals were informed by HEW through Part A Intermediary Letter No. 73-24 that the freeze on Old PIP had been extended until further notice pending a review. Again, no reason or explanation was given for this decision.

14. On September 1, 1973, Part A Intermediary Letter No. 73-37 was issued for use pending publication of new regulations. It created a New PIP method for hospitals and other providers electing coverage after August, 1973 and continued the freeze on Old PIP without explanation. Under the New PIP method, payments are made for a two week service period but are issued no earlier than two weeks after the end of the service period to which they apply. This new bi-weekly system resulted in an average lag of three weeks between delivery of service by the hospital and disbursement of payment for the service.

15. On January 16, 1974, the Secretary published a proposed regulation, 39 FR 2011, incorporating the provisions of intermediary letter 73-37.

16. On July 16, 1975, the final regulation establishing New PIP and specifically requiring hospitals to convert from Old to New PIP by September 15, 1975 was published, 40 FR 29815. As in the case of the publication of the earlier intermediary letters and proposed regulation, no reason was given for adopting New PIP in lieu of Old PIP. The Secretary did acknowledge, however, that he had received a great many objections to the New PIP regulation which asserted that the New PIP payment schedule

> "would severely hinder the cash flow of providers and their ability to meet working capital needs since a major share of providers' costs are associated with personnel payrolls and payments to vendors that are typically paid on at least a weekly or bi-weekly basis, and if such a proposal [for a three week lag period] is retained in the final regulations, many providers will be forced to borrow additional working capital from lending institutions, thereby incurring interests costs that will increase their

> overall cost of furnishing health care, a significant portion of which will be borne by Medicare." 40 F.R. 29816.

17. On September 2, 1975, the Secretary extended the date for complete implementation of New PIP to May 31, 1976 on the grounds that the original September 15 date would

> "create extraordinary cash flow problems for these hospitals, especially those located in the large urban centers, making it necessary for the hospitals to borrow equivalent funds from conventional lending sources." 40 F.R. 40192.

18. In October, 1975, Part A Intermediary Letter No. 75-58 containing the procedure whereby hospitals on Old PIP were to be converted to New PIP was issued. Under the terms of the Letter, a hospital's December 1 Medicare payment will be withheld, the hospital will be placed on a bi-weekly schedule on December 8 and then commencing December 22 an amount will be deducted from the hospital's subsequent bi-weekly payments so that by May 31, 1976 there will be an average three week lag between the rendition of Medicare services by the hospital and the receipt of payment.

19. If the members of the Class are forced to convert from Old PIP to New PIP they will be deprived of in excess of twelve million dollars in cash flow on December 1, 1975 and in excess of thirty-five million dollars in cash flow by May 31, 1976. These funds will never be repaid to the Class, even though they represent Medicare services already rendered. This enormous loss of funds, coupled with the three week delay in payment entailed under New PIP, will make it impossible for the members of the Class to meet

their current financial needs and pay for such items as salaries, which must be paid on a weekly basis.

20. Because Peninsula and the members of the Class have, in recent years, been suffering severe financial problems arising out of ever increasing costs necessary to furnish quality hospital services and restricted income, they are unable to cope with the sudden loss of cash flow referred to above. Any attempt to finance their needs from their own funds would either fail or be in contravention of HEW regulations which aim at ensuring that hospitals will not be required to finance the Government's cost of Medicare. Although there is no assurance that the Class members will be able to borrow the funds required to make up the loss of cash flow, such a requirement would also violate HEW regulations since HEW will only reimburse the hospitals for interest costs in an amount equal to that percentage of the hospitals' patient days represented by Medicare patient days. The balance of the interest costs would have to be borne by non-Medicare beneficiaries. This would violate the Medicare Act and regulations which prohibit shifting the costs of Medicare to non-Medicare patients.

21. For the most part, members of the Class will be unable to procure the funds lost as a result of the proposed action by HEW and would either have to cut back or eliminate essential hospital and health related services or cease operations entirely. In either event, the members of the Class and the public would suffer irreparable injury.

22. The Class members are already experiencing severe operating deficits as a result of their commitment to providing quality health care to the indigent and working poor of this City. They should not be forced to take on the additional financial burden of subsidizing the federal government at the expense of the citizens of New York.

STATEMENT OF CLAIMS

23. By enacting the regulation and applying it to the Class, defendants have violated the Medicare Act which requires that hospitals be reimbursed for their reasonable costs. The implementation of the regulation will result in the withholding of the payment of the hospitals' reasonable costs on December 1 and the withholding of a portion of their reasonable costs every two weeks thereafter until May 31, 1976.

24. By enacting the regulation and applying it to the Class, defendants have violated the Medicare Act which provides that "the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] . . . will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare] . . . ." The interest which the hospitals will incur if they are able to borrow to make up for the loss of funds resulting from New PIP will only be partially reimbursed by Medicare. The remainder will have to be paid by non-Medicare beneficiaries.

25. By enacting the regulation and applying it to the Class, defendants have violated existing Medicare regulations which require that providers be reimbursed the reasonable cost of services furnished Medicare beneficiaries;

that the costs of Medicare beneficiaries not be borne by non-Medicare beneficiaries; that the providers not be disadvantaged by having to put up money for the purchase of goods and services well before receiving reimbursement; and that interim payments be made to providers of hospital services on the most expeditious basis administratively feasible.

26. The promulgation of the regulation and its application to the Class is arbitrary, capricious, an abuse of discretion, in excess of defendants' authority and not in accordance with law, all in violation of the Administrative Procedure Act. Defendants have failed to offer any rational basis for discontinuing a payment procedure upon which the hospitals have relied since 1968. On the contrary, the available evidence demonstrates that the regulation will create an enormous financial crisis for the Class.

28. The conversion from Old PIP to New PIP as proposed by defendants, entailing as it does the withholding of reimbursement payments rightfully belonging to the Class, constitutes a deprivation of property without due process of law in violation of the Fifth Amendment to the Constitution of the United States.

WHEREFORE, Plaintiffs pray:

(a) That this Court declare and adjudge that the regulation entitled "Periodic Interim Payments to Title XVIII Providers", 40 F.R. 29815 (July 16, 1975), as amended by notice published in 40 F.R. 40192 (September 2, 1975), is unlawful in its application to the Class;

(b) That this Court preliminarily and permanently enjoin defendants and their officers, agents, servants, employees and attorneys from applying, or attempting to apply, such regulation to the Class; and

(c) That Plaintiffs be awarded such other and further relief as to this Court may seem just and proper.

PROSKAUER ROSE GOETZ & MENDELSOHN

By_____

Jacob Imberman
A member of the firm
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022
593-9200

EXHIBIT 1 ANNEXED TO COMPLAINT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
IHI-324

ADVANCE COPY.

October 1975

PART A INTERMEDIARY LETTER NO. 75-58

SUBJECT: Periodic Interim Payments (PIP) - Conversion from Weekly to Bi-Weekly Cycle

General

Enclosed is a copy of the final regulations concerning Periodic Interim Payments (PIP) as published in the July 16, 1975, Federal Register and the Notice published in the September 2, 1975, Federal Register which changed the date by which full implementation of the regulations must be accomplished.

The purpose of this intermediary letter is to explain the effect of these regulations on providers receiving weekly PIP payments and to furnish instructions for conversion to the bi-weekly cycle required by the regulations.

Background

As you will recall, PIP was first made available in 1968 as a method of interim reimbursement for hospital Part A inpatient services. Hospitals that elected to receive interim reimbursement under this method have been receiving PIP payments on a weekly basis. These payments apply to covered Part A inpatient hospital services furnished beneficiaries by the hospital during the seven day period ending with the date on which each PIP payment is issued. These payments contain an average lag of three days between delivery of services and disbursement of payment for these services.

In January 1973 a moratorium was placed on further conversions to PIP. This restriction was lifted in September 1973 (see IL Part A 73-37) and PIP was made available to other hospitals and to SNF's for Part A inpatient services and to HHA's for both Part A and Part B home health services but the method for computing and disbursing PIP payments to these providers was modified. Providers reimbursed under the modified method receive PIP payments for a two week service period and these payments are issued no earlier than two weeks after the end of the service period to which they apply. PIP payments under the modified method contain an average lag of three weeks between delivery of service and disbursement of PIP payment for these services.

Hospitals receiving weekly PIP payments under the original PIP method were permitted to continue to receive these payments pending publication of final regulations pertaining to PIP.

PIP Regulations

The enclosed regulations require that PIP payments cover a two week service period and be issued no earlier than two weeks after the end of the service period. PIP providers are also required to submit fully completed billing forms for the services for which they are receiving PIP payments.

PIP payments disbursed under the method set forth in IL Part A 73-37 are not affected by these regulations. They fully reflect the requirements in the regulations. The practical effect of the regulations, therefore, is that the PIP service period of providers being reimbursed under the original PIP method must be extended from one to two weeks and intermediary disbursement of PIP payments to these providers must be no earlier than two weeks after the end of the service period to which each payment applies.

When these requirements are fully implemented, PIP payments to all providers will contain an average lag of three weeks between delivery of service and disbursement of payment for the services, as required by the regulations.

Instructions for Implementation of PIP Regulations

If the PIP service period of hospitals presently receiving weekly PIP payments is extended from one to two weeks, concurrent with a delay of two weeks in their intermediary's PIP disbursement schedule, some of the hospitals may experience a serious cash flow problem unless the effect of these conversions on the PIP payments to the hospitals is minimized. Therefore, the effect of these conversions on the PIP payments to these hospitals shall be gradually phased in by May 31, 1976, as explained below.

Weekly PIP payments may not be disbursed after the last week of November 1975. All intermediaries making weekly PIP payments are to convert to a bi-weekly (i.e., every other week) PIP disbursement cycle and the PIP service period of the hospitals to which weekly PIP payments were being made must be extended from one to two weeks no later than the end of November 1975. These conversions may be made earlier if mutually agreeable to the hospital and the intermediary. The effect of these conversions on the amount of the bi-weekly PIP payments to the hospital must be phased-in over the PIP payments disbursed between the conversion date and May 31, 1976. When all the adjusted bi-weekly PIP payments have been made, they will have the effect of moving the PIP disbursement date of the intermediary from the last day of the hospital's two week service period to 14 days after the end of this service period.

Example:

Hospital has been receiving weekly PIP payments of $100,000 and the intermediary has been disbursing these payments on Monday of each week. The hospital and intermediary agree that weekly PIP payments to the hospital

should continue to be made through the disbursement date of Monday, November 24, 1975.

The intermediary's PIP disbursement cycle for this hospital will be converted from weekly to bi-weekly as of November 24, 1975. The first bi-weekly PIP payment to the hospital will be disbursed Monday, December 8, 1975. It will be in the full amount of $200,000 and will cover the service period from November 25, 1975, through December 8, 1975. This change will replace the average 3 day lag with an average lag of 6½ days.

Effective December 9, 1975, the hospital's PIP service period will be extended from seven to 14 days. The amount of the second bi-weekly PIP payment disbursed on December 22, 1975, and all subsequent such payments disbursed through May 24, 1976, must be adjusted, in equal amounts, to gradually build in the remaining days of the average lag. This is accomplished as follows:

Monday Disbursement Date	Amount of PIP Payments to Phase-In Full Lag
November 24, 1975	$ 100,000 (last weekly PIP payment) (covers service period 11/18/75 thru 11/24/75)
December 1, 1975	none
December 8, 1975	$ 200,000 (1st bi-weekly payment) (covers service period 11/25/75 thru 12/8/75)
December 22, 1975	$ 183,333.33 1/
January 5, 1976	$ 183,333.33
January 19, 1976	$ 183,333.33
February 2, 1976	$ 183,333.33
February 16, 1976	$ 183,333.33
March 1, 1976	$ 183,333.33
March 15, 1976	$ 183,333.33
March 29, 1976	$ 183,333.33
April 12, 1976	$ 183,333.34
April 26, 1976	$ 183,333.34
May 10, 1976	$ 183,333.34
May 24, 1976	$ 183,333.34
Total	$2,400,000.00
June 7, 1976	$ 200,000 (covers service period 5/11/76 thru 5/24/76)
June 21, 1976	$ 200,000 (covers service period 5/25/76 thru 6/07/76)

1/ In this example, the total value of the lag is the equivalent of payment for 14 days, in this case $200,000.

Thereafter, that is after May 1976, payments will continue to be bi-weekly but at the full amount of the then current bi-weekly PIP payment.

The above example does not take into consideration possible change in PIP payment amounts resulting from recomputation of the PIP payment following submission of the provider's cost report as required by PRM 2107.5, or the quarterly or other recomputations required by PRM 2407.7. Intermediaries must, when making these recomputations take the steps necessary to insure that full implementation of the PIP regulations payment lag by May 31, 1976, is not prevented by any adjustment to the provider's PIP amount.

Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosures

Order to Show Cause With Temporary Restraining Order

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Judge Metzner

75 Civ. 5902

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants.

ORDER TO SHOW CAUSE WITH TEMPORARY RESTRAINING ORDER

Upon the summons and complaint herein, and upon the affidavits of Philip C. Abrams, Joseph L. Bloch and Peter B. Terenzio, all sworn to the 19th day of November, 1975, the affidavit of Kenneth F. Adamec sworn to the 20th day of November, 1975, and the affidavit of Irwin M. Birnbaum sworn to the 21st day of November, 1975, and upon the Certification of Notice of Susan Rosenfeld and upon all proceedings had herein, and good cause appearing therefor, it is hereby

ORDERED that defendants, their officers, agents, servants, employees and attorneys appear before this Court in Room 2703 of the United States Courthouse, Foley Square, New York, New York, on the 28 day of November, 1975, at 10:30 o'clock in the fore noon of that day, or as soon thereafter as counsel can be heard to show cause why an order should not be entered granting plaintiffs a preliminary

injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure pending final determination of this action restraining defendants and their officers, agents, servants, employees and attorneys from applying, or attempting to apply the newly promulgated Periodic Interim Payments regulation for Medicare reimbursement contained in 20 CFR §405.454(j) to the plaintiffs or the members of the Class herein; and it further appearing to the Court from the complaint and affidavits above mentioned that a temporary restraining order preliminary to the hearing upon plaintiffs' motion for a preliminary injunction should issue because of the proposed unlawful application of the regulation; that defendants unless enjoined threaten to enforce this regulation; that the application of the regulation to the Class will likely occur prior to said hearing date unless restrained by an order of this Court; that the application of the regulation to plaintiffs and the Class will cause them immediate and irreparable injury before the hearing can be held on plaintiffs' motion for a preliminary injunction in that it will seriously and permanently impair the ability of the Class to render hospital and health services to the public; and plaintiffs having made no previous application for the relief requested herein, it is hereby

ORDERED, that for a period not to exceed ten days after the entry of this order or until the 1 day of December 1975 at 4 o'clock in the after noon or as soon thereafter as counsel can be heard, unless this order be dissolved prior thereto or extended then or thereafter whichever is sooner,

Defendants, their officers, agents, servants, employees and attorneys be and hereby are, temporarily enjoined and re-

strained pending the hearing and determination of this motion, from applying or attempting to apply, the newly promulgated Periodic Interim Payments reimbursement regulation contained in 20 CFR §405.454(j) to the plaintiffs or the members of the Class herein; and it is further

ORDERED that, personal service by Philip Castellano, Jr. of 49-1A Richmond Boulevard, Ronkonkoma, New York 11779 of this order to show cause and temporary restraining order together with a copy of the papers upon which it is based upon the United States Attorney for the Southern District of New York if made on or before 3 o'clock in the ~~for~~ noon of the 21 day of November, 1975 ~~or, if properly mailed on or before o'clock in the noon of the day of November, 1975~~ shall be deemed sufficient service thereof.

Dated: New York, New York
November 21, 1975

~~ISSUED~~ AT
3 P M

/s/ CHARLES M metzner
United States District Judge

after argument hearing
Jacob Imberman for plaintiff
Frederick Schaffer for defendant

All papers to be served by plaintiff on defendant by noon November 25, 1975 and defendant to serve answering papers by 10AM on November 28, 1975

CMM

Affidavit of Philip C. Abrams in Support of Application

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION, et al.,

Plaintiffs,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, et al.,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
SS.:
COUNTY OF NEW YORK)

PHILIP C. ABRAMS, being duly sworn, deposes and says:

1. I am the Executive Director of The Jewish Hospital and Medical Center of Brooklyn and have held that position since August, 1971. I have held various positions in hospital administration since 1948 when I graduated from Columbia University with an M.S. in Hospital Administration. During that period of time I have been associated with the Shore Road Hospital in Brooklyn, Doctors Hospital of Staten Island, Maimonides Medical Center of Brooklyn, as well as the hospital with which I am now associated. I am a member of the American College of Hospital Administrators and I am fully familiar with the facts hereinafter stated.

2. I make this affidavit in support of the plaintiffs' application for a temporary injunction restraining the defendants from changing the manner in which they make periodic interim payments (PIP) to hospitals involved in the

Medicare program.

3. The Jewish Hospital and Medical Center of Brooklyn is the only major voluntary teaching hospital in northern Brooklyn which includes part of the Bedford-Stuyvesant area. The area which we serve is probably the most economically deprived area in the city. The hospital has about 640 beds and in 1974 we provided about 225,000 patient days of hospital service. Our hospital is the only hospital of its kind which is available to render the sorely needed health care in this immediate community.

4. If the defendants' plan for changing PIP goes into effect the hospital will lose about $600,000 in cash flow. This results from the fact that at the present time the PIP payments which the hospital now receives contain an average lag of three (3) days between delivery of services and disbursement of payment for these services. Under the change which the government proposes to inaugurate PIP will contain an average lag of three (3) weeks between delivery of services and disbursement of PIP payment for the use of services. We are being asked to finance the government and we are in no position to do so. We will be permanently deprived of this money and a loss of these funds would cripple the hospital's ability, possibly beyond redemption, to provide the services to the people who depend upon it.

5. The hospital's most recent financial statement indicates a deficit in its net working capital of over $4,000,000. It is impossible for the hospital to borrow money from any bank on the basis of its present financial statements and its inability to furnish collateral. I could

not recommend to our Board of Trustees that the hospital borrow such money because I know of no way in which the money could be repaid. The hospital is now about ninety (90) days behind in the payment of bills to its vendors. The loss of $600,000 in cash flow would force the hospital to fall an additional two months behind in these services. I do not believe that our vendors would be willing to wait five (5) months to get paid. The inevitable result would be that many of them would just stop supplying the hospital with needed goods and services. This would result in a catastrophe because the hospital would be unable to operate.

6. Cash flow is of critical important to a hospital because over 70% of its operating expenses are represented by cost of labor. The people who work for the hospital must be paid every week and any act by the defendants which cuts down on the hospital's cash flow each week seriously jeopardizes the ability of the hospital to continue as a viable health care institution in this city.

7. Under these circumstances, I respectfully urge the Court to grant the plaintiffs' application and prevent the defendants from arbitrarily changing a method of payment for Medicare patients which has existed since 1968 and upon which we have relied in order to maintain our Medicare program.

PHILIP C. ABRAMS

Sworn to before me this
19th day of November, 1975

Notary Public

JACOB FUHRMAN
NOTARY PUBLIC, State of New York
No. 30-7023030
Qualified in Nassau County
Term Expires March 30, 1976

Affidavit of Joseph L. Bloch in Support of Application

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION, et al.,

Plaintiffs,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, et al.,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
SS.:
COUNTY OF NASSAU)

JOSEPH L. BLOCH, being duly sworn, deposes and says:

1. I am the Vice-President-Administration of the Peninsula Hospital Center, hereinafter (the "Hospital" or "Peninsula") which is located on Beach Channel Drive in Far Rockaway. I am fully familiar with the facts hereinafter stated and I make this affidavit in support of the plaintiffs' application for a temporary injunction restraining the defendants from changing the manner in which the hospitals in the Class represented by the plaintiffs, receive payments under the Periodic Interim Payment Program (PIP) reimbursing hospitals for services under the Medicare program.

2. If the defendants' plan for changing PIP goes into effect, the Hospital's cash flow would be reduced permanently by approximately $450,000. Our present weekly payments from PIP are about $148,000. Because of the difficult financial situation in which the Hospital now is, it

cannot tolerate the removal of about $450,000 cash flow during the next year. Under the modified PIP program the Government would stretch out the average lag between our delivery of service to Medicare patients and the receipt of payment therefrom, from 3 days to 3 weeks. We are being asked to finance the Government and we are just not in a position to do so. If we are permanently deprived of these monies, our ability to provide medical services to the people in our community who need it would be sharply curtailed.

3. Peninsula is a community hospital serving the Rockaway peninsula, Mill Basin and Howard Beach areas in the City of New York, as well as the Five Towns area of Nassau County. The population in the area served by the Hospital is geriatric to a large extent. During the last few years the Rockaway peninsula has seen a proliferation of skilled nursing homes, health-related facilities, and urban renewal projects resulting in a large population of senior citizens. This has resulted in an ever increasing Medicare population in the Hospital and at the present time approximately 60% of our patient days are Medicare.

4. The Hospital has approximately 285 beds and in 1974 we had about 95,000 patient days. We have an extremely active emergency room, although the size of the Hospital and the number of visits is not comparable to a large urban center. It is substantial for a community hospital. It is well known that emergency room service is rendered at a loss because the Hospital must render care to all who come to the emergency room. At Peninsula this is compounded by the fact that there is a great influx of people to our beaches during the summer months. Many of the

people who use the emergency room are between the ages of 21 and 64, not eligible for Medicaid and purport to have meager incomes. They claim they are unable to pay for emergency room treatment, although we try to collect whatever we possibly can from them. This is a very difficult task, especially from the people who are classified as "the working poor."

5. Recently, in order to alleviate our difficult financial condition and to buy the time which we require to put into effect a long range program of improvements, we were able to secure a working capital loan from The Chase Manhattan Bank of $1,200,000 which we agreed to repay over a five-year span. We are unable to borrow any more money for working capital and we have no collateral which we can post as security for such a loan.

6. At the present time, and after receiving the working capital loan, the Hospital is paying its vendors about 110 days after receipt of invoices. If $450,000 is removed from our cash flow over a six-month period, the result would be disastrous to this Hospital. We would be closer to 9-10 months behind in payments to our vendors and will also fall behind in the payment of taxes. There is no doubt in my mind that vendors would refuse to serve us and the deprivation of materials and supplies that we need to operate the Hospital would be catastrophic.

7. I emphasize here that the Medicare patient percentage at Peninsula is probably the highest in the New York City area. The new PIP program would remove approximately 5% of our total working capital.

8. Cash flow is of critical importance to a hospital because over 70% of its operating expenses is represented by the cost of labor. We must pay our employees weekly. The defendants' proposal which would cut down on the Hospital's cash flow each week would seriously jeopardize the ability of the Hospital to continue to render services to the aging population in our community.

9. Under these circumstances, I respectfully request that the plaintiffs' motion for a temporary injunction be granted and the defendants be enjoined from changing the present method of paying for Medicare services.

JOSEPH L. BLOCH

Sworn to before me this
19th day of November, 1975

NOTARY PUBLIC

JACOB INDERMAN
NOTARY PUBLIC, State of New York
No. 30-7033000
Qualified in Nassau County
Term Expires March 30, 1976

Affidavit of Peter B. Terenzio in Support of Application

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION, et al.,

Plaintiffs,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, et al.,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
SS.:
COUNTY OF NEW YORK)

PETER B. TERENZIO, being duly sworn, deposes and says:

1. I am the Executive Vice President of The Roosevelt Hospital (the "Hospital"), which is a voluntary nonprofit institution located at 428 West 59th Street, in the City of New York. I am fully familiar with the facts hereinafter stated. The Hospital has approximately 595 beds and in 1974 provided over 190,000 patient days of hospital service.

2. I graduated from the University of Connecticut in 1940 with a degree of Doctor of Jurisprudence; from Northwestern University in 1950 with a degree in Master in Health Administration. From June 1948 to June 1949, I was employed as Administrative Assistant in the Hospital Standardization Department at the American College of Surgeons. Since 1950, I have acted in various capacities as a Hospital Administrator. From 1950 to 1952, I was the Assistant Director at The Roosevelt Hospital. Thereafter,

I served for one year as Director of the Greenville General Hospital in Greenville, South Carolina. In 1953, I returned to The Roosevelt Hospital where I have been the Executive Vice President for twenty-two years.

3. The Hospital generally serves the following area: from 34th Street north to 86th Street, and from Fifth Avenue west to the Hudson River, in the Borough of Manhattan. It services a mixed population including persons who are on the poverty level, working poor, as well as middle-class citizens of our community.

4. I make this affidavit in support of the application of Greater New York Hospital Association to enjoin the Secretary of Health, Education and Welfare ("HEW") and the Commissioner of Social Security from applying the newly promulgated Periodic Interim Payments reimbursement method contained in 20 CFR §405.45(j) to the Class. This method (new PIP) would substitute an average three-week lag for the three and one-half day lag which presently exists between delivery of Medicare services by the Hospital and payment therefor by HEW. In order to effect this change, HEW plans to withhold from the Hospital the sum $226,800 which it should receive on December 1, 1975, place the Hospital on a bi-weekly reimbursement schedule on December 8th instead of the present weekly schedule, and then deduct $37,800.00 from each hospital payment from December 22 to May 31, 1976. This will result in a total permanent loss to the Hospital of approximately $680,400 in cash flow.

5. The loss of this cash flow would be catastrophic to the Hospital. It would not be able to borrow

money to replace this loss because it has already exceeded its borrowing limitations. Further monies could not be borrowed without collateral and the Hospital does not have any collateral which it could deposit with the bank to secure any loans. In addition, I do not see how I, as a responsible officer, could recommend to the Board of Trustees that it borrow this money from a bank since I cannot see any way that the Hospital could ever repay such a loan. As of December 31, 1974, the Hospital had a deficit in its working capital position of over $2,000,000. Cash flow is critical to the Hospital since the cost of labor represents about 70% of its expense. Our payroll must be met weekly.

6. The Hospital has no further unrestricted endowment funds that it can use for this purpose. The last of such funds having been expended recently.

7. The Hospital now pays its vendors from 90 to 120 days after they supply it with merchandise. The loss of cash flow which is contemplated by the defendants in this action would cause the Hospital to delay payment to its vendors for an additional two months. I am positive that many vendors would refuse to furnish the Hospital with supplies and needed materials if they would not be paid until 4 or 5 months after they had sold these materials and supplies to the Hospital. Without such supplies, I do not know how the Hospital could continue to operate. It would obviously have to cut back or eliminate various health service programs which it now furnishes the people of the City of New York.

8. Like all other voluntary institutions, The Roosevelt Hospital has been caught between the rapidly rising spiral of inflation and the demands made upon it for greater and better hospital and health related services. The people of the City of New York rely on our Hospital as well as other voluntary hospitals for such services and we cannot render them unless we receive prompt payment for the services which we supply.

9. The fiscal crisis which the City of New York is now involved in has also served to severely hamper our own operations. In addition to the Medicaid Program which is financed in part by the City of New York, we are also involved in the Ghetto Medicine Program and the Community Mental Health Program. In each of these programs, payments which we are entitled to receive from the City have been drastically reduced despite the fact that we have continued to furnish the services which are so desperately needed by the community.

10. If the Government's change in the payment for Medicare services is put into effect, we would be required to furnish services to Medicare patients without being compensated for such services for a period of three weeks. Since Medicare patients represent about 26% of the Hospital's population, we would be required to furnish a substantial amount of hospital services for this period of time without current payment. The Hospital does not have the financial ability to carry out such a program.

WHEREFORE, it is respectfully requested that the plaintiffs' motion for a temporary injunction be granted

and the defendants be enjoined from making any changes in the current manner in which the members of the Class are being reimbursed for the hospital and health related services furnished to patients under the Medicare program.

Peter B. Terenzio
PETER B. TERENZIO

Sworn to before me this

19thday of November, 1975

Konstantin Sibirtzeff
Notary Public

KONSTANTIN SIBIRTZEFF
NOTARY PUBLIC, State of New York
No. 41-4512525
Qualified in Queens County
Commission Expires March 30, 1977

Affidavit of Kenneth F. Adamec in Support of Application

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION, et al.,

Plaintiffs,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, et al.,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
SS.:
COUNTY OF BRONX)

KENNETH F. ADAMEC, being duly sworn, deposes and says:

1. I am President of Misericordia Hospital Medical Center (the "Hospital"), which is located at 600 East 233rd Street, in the Bronx. The Hospital generally serves a broad cross-section of the people who live in the north-eastern part of the Bronx. The Hospital has 380 beds and in 1974 it supplied 128,690 patient days of hospital service in the community.

2. I graduated from Bucknell University in 1954 and received a B.S. degree. I received a Masters of Science degree in Hospital Administration from Columbia University in 1958. I am a Fellow of the American College of Hospital Administrators and a Fellow of the American Public Health Association. From 1958 to 1962, I was an Assistant Director of St. Barnabas Hospital. Thereafter, I joined Misericordia Hospital Medical Center which I now serve as President.

3. I am fully familiar with the facts hereinafter stated and I make this affidavit in support of the plaintiffs' application for a temporary injunction to enjoin the defendants from changing the manner in which the Hospital receives payment for services rendered to Medicare patients. At the present time, there is an average lag of about three days from the delivery of services by the Hospital to the receipt of payment for these services. The program under which we receive these payments is called Periodic Interim Payments (PIP), which was originally established by the Department of Health, Education and Welfare (HEW) in 1968. The Department now proposes to change the method of payment so that there will be an average lag of three weeks between the delivery of service by the Hospital and the receipt of PIP payment for these services.

4. The change in the PIP program will seriously aggravate the financial problems which the Hospital has. Misericordia is now receiving approximately $130,000 a week under the PIP program. By the end of May, 1976, if the new PIP program is effective, the Hospital will suffer a loss of $400,000 in cash flow. The Hospital has no way of making up this loss which, for all practical purposes, will be permanent. At this time, the Hospital has an outstanding loan with the Manufacturers Hanover Trust Company for the construction of its ambulatory care facility. The terms of this loan specifically prohibit the Hospital from borrowing any additional funds without the written consent of the bank. I do not see how we can ever get the bank to lend us additional money for operating expenses since we have no collateral to post as security and I do not see how under the present circumstances we would ever be able to repay the money.

5. Approximately 40% of the Hospital's patient days are Medicare patient days. Thus, Misericordia will be severely effected by the change in the manner of payments under the new PIP program and the proportionate effect on this Hospital is much greater than on other hospitals.

6. Misericordia is already 95 days behind in the payment of vendors' invoices. I am informed that the Hospital's fiscal staff regularly receives calls from vendors who refuse to ship merchandise which is sorely needed by the Hospital unless they are paid within 30 to 60 days. The effect of the new PIP program and its concomitant cash flow lag would cause Misericordia to fall 110 days behind in the payment of its vendors' invoices. I am certain that some vendors would refuse to ship merchandise to us under such circumstances. The result would be catastrophic to the Hospital for we would have to eliminate or sharply curtail services in the Hospital if we are deprived of materials which we need in order to function properly.

7. Misericordia is also involved in the City and State of New York in two programs, the funds of which have been drastically reduced recently because of the fiscal crisis in which the City and State are involved. These essential programs are the Ghetto Medicine Program and the Community Mental Health Program. The amount which we should receive from the City and State for these programs is approximately $500,000 a year. Since the fiscal year ended June 30, 1975, funds for these programs have been cut in the amount of $150,000 despite the fact that the Hospital is continuing to furnish services requested under these programs.

8. Misericordia has been operating its Out-Patient Department at a loss of approximately $785,000 per annum after receipt of all funds from the Ghetto Medicine Program and Community Mental Health Program.

9. As far as I know, HEW has advanced no reason at all for making this arbitrary change in payments upon which we have relied for seven years.

10. If the new PIP program is put into effect and the Hospital suffers the loss of cash flow to which I have referred, the result inevitably must be that we will have to reduce the services which we render to the community. Since these services are desperately needed and there is no alternative source to replace our Hospital, it is clear that the Hospital and the people of the community which it serves will suffer irreparable injury. Under these circumstances, it is respectfully requested that the plaintiffs' application for a temporary injunction be granted.

KENNETH F. ADAMEC

Sworn to before me this
20 day of November, 1975.

NOTARY PUBLIC

DIVA DELLA CAMERA
NOTARY PUBLIC, State of New York
No. 03-5971765
Qualified in Rockland County
Commission Expires March 30, 19..76

Affidavit of Irwin M. Birnbaum in Support of Application

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION, et al.,

Plaintiffs,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, et al.,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
SS.:
COUNTY OF NEW YORK)

IRWIN M. BIRNBAUM, being duly sworn, deposes and says:

1. I am the Deputy Director for Fiscal Affairs for Montefiore Hospital and Medical Center, (Montefiore) a voluntary teaching hospital of 1302 beds, located at 111 East 210th Street, Bronx, New York. Montefiore provides hospital and health care for the residents of the Bronx and lower Westchester, many of whom are indigent or working poor. Montefiore is the largest provider of Medicare services in the United States. In 1974, services to Medicare beneficiaries represented 45% of its 423,734 patient days.

2. I am fully familiar with the facts hereinafter stated and make this affidavit in support of plaintiffs' motion for a temporary restraining order and preliminary injunction enjoining the Secretary of Health, education and Welfare (HEW) and the Commissioner of Social Security from applying the newly promulgated Periodic

Interim Payments reimbursement method contained in 20 CFR §405.454(j) to plaintiffs and the Class they represent.

3. This method (New PIP") would substitute an average three week lag for the 3-day lag which presently exists between delivery of Medicare services by the hospital and payment therefor by HEW. In order to effect this change, HEW plans to withhold the hospital's December lst Medicare payment of $881,900, place the hospital on a bi-weekly instead of a weekly reimbursement schedule on December 8th, and then deduct $146,983.33 from each hospital payment from December 22nd to May 31, 1976. This will result in a total permanent cash flow loss to the hospital of $2,645,700. This loss will create a serious fiscal problem for the hospital and, depending on the financial situation in New York, may cause the hospital to cut back on the services which it provides.

4. I became associated with Montefiore Hospital in 1963, and am presently the Deputy Director for Fiscal Affairs. Prior thereto, I was the Assistant to the Administrator for Fiscal Affairs for approximately four years, and Budget Officer for approximately three years. Before joining the hospital staff, I served as Accounting Manager for General Economics Corporation for approximately one year, as an accountant with Wright Long & Co. for approximately one year, and as an accountant with Robert Simons & Co. for approximately five years. I am a member of the following hospital and financial organizations: American Public Health Association, Hospital Financial Management Association, Hospital Association of New York State-Committee

on Finance, and the Greater New York Hospital Association-Committees on Affiliations, Reimbursement and Blue Cross Negotiations. I am Chairman of the Finance Committee of the League of Voluntary Hospitals. I am a member of the New York State Bar and have a Bachelor of Science degree from Brooklyn College and a Juris Doctor Degree from the New York University School of Law.

5. Prior to 1968, HEW would only reimburse a hospital for Medicare services upon receipt of completed patient billings. As a result, hospitals frequently experienced considerable delays between the time that they rendered services to Medicare beneficiaries and the time they received payment therefor. This created a serious cash flow as well as an administrative problem for these institutions, particularly those in large urban areas which had substantial emergency room and outpatient department operating deficits. To rectify this situation, HEW, in 1968, offered hospitals the option of being paid under a new system known as "Periodic Interim Payments" ("Old PIP"). Under the Old PIP system, a hospital receives a weekly payment equal to 1/52nd of its total estimated annual Medicare costs regardless of the number of bills submitted. Hospitals are still required to complete and submit payment invoices which are subject to final audit and adjustment. However, these billings are no longer a prerequisite to payment.

6. On July 16, 1975, the Secretary of HEW published final regulations establishing a New PIP system and requiring hospitals on Old PIP to convert to this new

payment method. No reason was given for the elimintation of Old PIP. Under New PIP, a hospital is paid bi-weekly two weeks after the service is provided and has to wait an average of three weeks between the time it renders services to a Medicare beneficiary and the time it receives payment therefor. The process by which hospitals on Old PIP are to convert to New PIP is detailed in Part A Intermediary Letter No. 75-58 of October, 1975, annexed to the complaint herein as Exhibit 1. Under the terms of this letter, a hospital's December 1st Medicare payment will be totally withheld, the hospital will be placed on a bi-weekly payment schedule starting December 8th instead of the present weekly schedule, and deductions will be taken from the hospital's subsequent bi-weekly payments starting December 22nd in an amount sufficient to place it on a three week lag by May 31, 1976.

7. The implementation of the New PIP system will result in a permanent loss of $2,645,700 in cash flow to Montefiore, the amount of money which HEW must withhold in order to institute the three week lag. The only way in which Montefiore can make up this loss in cash flow is to borrow the money. I have been advised by the hospital's banks that the interest rate for such a loan will be 1% above prime. There is no question but that this extensive borrowing will seriously impair the future borrowing ability of the hospital for its normal purposes. Moreover, subject to certain limitations, Medicare only reimburses the hospital a percentage of the interest cost equal to the percentage of a hospital's days which are Medicare patient days. Since Montefiore's Medicare patient day percentage is 45%, only that amount of its interest at most will be

reimbursed by HEW. The remainder will have to come from other sources of income, namely, the hospital's non Medicare beneficiaries and other third party payors such as Medicaid and Blue Cross.

8. At the present time, the hospital has a commitment from its banks to borrow approximately $881,000, which is the amount that HEW will withhold from it on December 1st. I have no way of knowing whether the hospital will be able to borrow the remaining $1,762,000 which HEW will withhold by May 31, 1976. Certainly, the hospital will not be able to make up this loss from its own funds. The precarious financial situation in which the City and State of New York now find themselves will have an important effect on the hospital's ability to borrow large sums of money from the banks.

9. The loss of Medicare revenues which will result from the implementation of the New PIP regulation comes at a time when Montefiore can least afford it. As a result of its fiscal crisis, New York City is $420,000 behind in its payment of Ghetto Medicine Funds to the hospital, and $700,000 behind in its payment of funds to the hospital for health services performed at Rikers Island Hospital and Spofford Juvenile Detention Center in the Bronx. It also appears that the hospital's 1975 deficit for outpatient and emergency room services will be well in excess of its 1974 deficit of $1,142,000. This loss in revenues and the worsening fiscal situation in the City will make it increasingly difficult for the hospital to continue to borrow funds to meet its working capital needs. It is a very real possibility that the hospital in the near future will therefore be

unable to secure adequate financing, and will be forced to curtail health services. The victims of these cutbacks will be the millions of people in the Bronx and Westchester who depend primarily on Montefiore for their medical care as well as the people throughout the world who rely on its highly unique and specialized services.

10. Plaintiffs' motion for a temporary restraining order and preliminary injunction were not brought prior to this time because the New York hospitals were advised that negotiations aimed at exempting hospitals in the greater New York area from the New PIP regulation were in progress in Washington. In order not to jeopardize these discussions, the hospitals were requested to postpone any legal action until November 11th, at which time the question of the implementation of the PIP regulation was to be considered by the Special White House Task Force on New York City. On November 11th the hospitals were informed that the attempt to arrive at a favorable solution to this problem had failed.

11. No previous application for the relief sought herein has been made to this or any other Court.

WHEREFORE, it is respectfully requested that the plaintiffs' motion be granted, and the defendants be enjoined from implementing the new regulation which would change the manner in which the members of the Class would be reimbursed for services rendered to Medicare patients.

/S/ IRWIN M. BIRNBAUM
IRWIN M. BIRNBAUM

Sworn to before me this
21st day of November, 1975
/S/ Lawrence Goldman
Lawrence Goldman
Notary Public, State of New York
No. 60-6571655
Qualified in Westchester County

Certification of Notice of Susan Rosenfeld

I affirm that Mr. Adams ~~Abrams~~ of the United States Attorney's office for the Southern District of New York has been given notice of this application for a temporary restraining order on November 20, 1975 by telephone

11/21/75 Susan Rosenfeld

bjmjb **Transcript of Proceedings**

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, ET AL,

Plaintiffs,

vs. 75 CIV 5902

DAVID MATTHEWS, ET AL,

Defendants.

November 28, 1975
10:30 a.m.

BEFORE:

HON. CHARLES M. METZNER,

District Judge.

A P P E A R A N C E S:

THOMAS J. CAHILL, ESQ.
United States Attorney for the
Southern District of New York,
One St. Andrew's Plaza,
New York, N.Y.
BY: FREDERICK P. SCHAFFER, ESQ.,
TAGGART D. ADAMS, ESQ.,
Assistant United
States Attorneys

PROSKAUER, ROSE, GOETZ & MENDELSOHN, ESQS.
Attorneys for defendants,
300 Park Avenue,
New York, N.Y.
BY: JACOB IMBERMAN, ESQ.,
SUSAN C. ROSENFELD, ESQ.,
Of Counsel

MR. IMBERMAN: The defendant is ready.

MR. SCHAFFER: The plaintiff is ready.

THE COURT: From the Government's brief submitted this morning, it is their viewpoint we are dealing with a non-appealable order. It would seem to me that we ought to have an argument on that before we proceed further. Mr. Schaffer.

MR. SCHAFFER: Yes, your Honor. As the defendants pointed out in their brief, Section 10 of the APA 5 USC Section 701(a)(2) provides that the provisions for judicial review of that chapter in the APA are not applicable to the extent that the agency view is submitted--the Government recognizes that is a narrow decision. The Government said it is applicable in the rare instances where statutes are drawn in such broad terms that in a given case there is no law to apply.

It is the Government's contention that this is precisely such a case. 42 USC Section 1395(g), which gives the secretary the authority to determine when and how interim payments will be made, states that the secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it. And the provider of services shall be paid at such time or times as the

secretary believes appropriate, but no less often than monthly.

Now, it is the Government's contention that this language, as the secretary believes appropriate, is a clear indication of a Congressional intent to commit that decision to agency discretion as long as the payments are made at least once a month. This is not a case such as Citizens to Preserve Overton Park versus Volpe where we are dealing with statutes which specifically limit the authority of the secretary to take a certain decision and provide guidelines on the basis of which he is to make that decision.

In Overton Park, the Supreme Court held that the agency decision to build a highway through a park area was not submitted to agency discretion because there was law to apply. The statute in that case required the secretary to make a determination that no other feasible route for the highway could be found, and that the particular route that he chose would minimize the room on the park land.

Here we are dealing with a statute that provides no such factors for the secretary to consider. And, therefore, provides no basis for judicial review. The statute says that the secretary may make payments at such times as he believes appropriate. It follows that the secretary has made a determination of the times he believes appropriate.

In view of that open-ended language, it is the

Government's position that we have here a case where there cannot be judicial review because there is no standard to be applied, but rather this is a situation where Congress has indicated its intent that the decision be committed to agency discretion. And, therefore, not subject to judicial review.

THE COURT: Mr. Imberman.

MR. IMBERMAN: If your Honor please, I must confess that I received the Government's brief at about 10:15 this morning. I have literally not had a chance to read it.

However, I would like to respond to Mr. Schaffer's statement by saying that it is untrue that there are no standards in the statute to apply, because Title 42, Section 1395(x) of the statute, subdivision V1(a) says that the reasonable cost of services shall be paid to the provider. The statute goes on to say that this means direct and indirect costs. In the various regulations which have been promulgated, aside from the langugage which Mr. Schaffer discussed, that the secretary shall pay when he thinks appropriate, but at least once a month--there are specific regulations.

I will read one of them, your Honor. Section 405.454, and that says, and I quote, "While the law pro-

vides that interim payments shall be made no less often than monthly, intermediaries," in our case Blue Cross, "are expected to make payments on the most expeditious basis administratively feasible."

Now, I suggest, your Honor, that there can be no more imperative language than what is cited in the regulations, and when an agency has made payments to the voluntary hospitals on a weekly basis for almost eight years.

After having found that the prior basis of making payments was totally inadequate, and we will have a witness who will testify that when Medicare started and when hospitals were supposed to be paid on the basis of the billings that they rendered, the hospitals, Blue Cross and the Social Security Administration, became so bogged down in paper work that it was impossible to get money flowing into the hospital to take care of these patients.

As the result they started the PIP System which, in effect, separated the flow of paper from the flow of money. Hospitals would get weekly payments geared to their annual needs, and the paper work would catch up later. That has been done.

THE COURT: You are arguing to a point not made by the Government. The Government says that the discretion here was given to the Administrator by statute, and under

the Overton case, there is nothing for the Court to review. That's the issue he has posed.

MR. IMBERMAN: I would submit that there is, and I might cite one recent case in which another change in the regulations was attacked in this case by the American Hospital Association, and this is a decision by the District Court of the District of Columbia.

In that case it is the American Hospital Association against Weinberger.

THE COURT: Is that in your brief?

MR. IMBERMAN: Yes, it is in my brief. Now, in that case the Government attempted to change a regulation. Under the prior regulation the Government, as the result of studies, had recognized that Medicare patients require a considerable amount more nursing care than ordinary patients. And so there was what is called the 8.5 per cent differential paid to hospitals. Hospitals for routine nursing care for patients were given 8.5 per cent more than the ordinary amount. Last year the Government attempted to eliminate the 8.5 per cent. The American Hospital Association challenged that in an action in the District Court for the District of Columbia.

The judge granted summary motion to the plaintiffs, and set aside the regulation. The similar argument

was made by the Government in that case.

I have here a transcript of the entire argument on the motion for summary judgment, and Judge Hart's determination at the end of the argument. Judge Hart said that he had jurisdiction to determine whether or not the Government's change in the regulation was valid. He determined that the reasons they gave were totally irrelevant to the issue, and that the regulation that the Government was trying to impose then was totally contrary to the prior regulation.

Now, there just is no doubt in a situation like this where the Government, without any reason whatsoever, without advancing any reason whatsoever, issues a regulation which violates the statute because reasonable cost includes, if your Honor please, the cost of working capital. It includes that. It must.

The hearings before the Senate Finance Committee which we have cited in our briefs--the very regulations which HEW has issued plainly demonstrate that working capital is a necessary part of cost because the statute and the regulation speak of direct or indirect cost, standby cost. Let me give you one other example from the statute, your Honor.

The same statute I mentioned to you requires the

secretary, in prescribing the regulation by which the hospitals are reimbursed for their costs, to consider, and I am not quoting, "The principles generally applied by national organizations or established pre-payment organizations," in computing the amount of the payment.

Now, there is no more important national organization in this field than Blue Cross.

In this area Blue Cross is the fiscal intermediary. The Government's agent is to pay more than 85 per cent of the hospitals, and the principles they have established for payment hospitals is what the statute requires the secretary of HEW to regard and consider. Blue Cross in this area deposits in advance with the hospitals a sum of money equivalent to approximately 40 days of care that the hospital gives to Blue Cross subscribers.

The purpose of that, as Blue Cross knows and the entire industry knows, is because the hospitals do not have working capital.

Medicaid which is a similar Government sponsored method of paying for hospital care to poor people, does exactly the same thing. They deposit with the hospitals 90 days of payment. So if the statute requires the secretary to consider the principles established by such organizations and the secretary is attempting to vitiate such

principles and to take away from the hospitals the working capital which they must have, I would suggest that your Honor certainly has jurisdiction to consider the action, and to determine whether or not it is either in accordance with the Health Insurance Law or the Administrative Procedures Act because here there has been an absolute failure to give any reason whatsoever. And merely because the statute says that the secretary in his discretion may do something, that does not mean his discretion is wide open. It does not mean he can do anything he wants without giving a reason.

If your Honor will consider that if an injured party comes into Court and says that the action of the secretary violates the statute.

Now, I would like to suggest, your Honor, that we go ahead with this hearing and your Honor listen to the witnesses and give me an opportunity to respond to the brief which I have not even read yet.

THE COURT: All right. Go ahead and put your first witness on.

Mr. Ingram.

J A M E S C. I N G R A M, called as a witness, having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. IMBERMAN:

Q Where do you live, Mr. Ingram?

A 66 Dutch Hollow Drive, Orangeburg, New York.

Q Will you give the Court your educational background?

THE COURT: What is he being put on for?

MR. IMBERMAN: Mr. Ingram is an expert in the hospital reimbursement field, and now a consultant to hospitals.

THE COURT: Are you going to contest his qualifications?

MR. SCHAFFER: No, your Honor, we will stipulate to the qualifications.

THE COURT: Let's get down to the guts of this.

Q Mr. Ingram, is Blue Cross the Medicare intermediary in this area?

A One of two.

Q Who is the other intermediary?

A Traveler's Insurance Company.

Q Just what does a fiscal intermediary do in connection with the Medicare program?

A The fiscal intermediary handles all the payments made to the providers of care for services rendered to

Medicare beneficiaries.

Q Does the fiscal intermediary receive any financial reports from the hospitals?

A Yes, they do.

Q What is the form that those reports take?

A In New York it is the Uniform Financial Report filed annually, covering the prior year's operations.

Q Could you very briefly tell the Judge what is on a Uniform Financial Report that the hospital files with Blue Cross?

A The Uniform Financial Report is a comprehensive report covering the hospital's balance sheet, a reconciliation of the fund balances, a detailed statement of income, a detailed statement of expenses, sufficient statistical data to enable the intermediary to make a cost allocation in accordance with the regulations, and finally service statistics as to how many patients were admitted, patient days and clinical visits and emergency room visits and the like.

Q Does Blue Cross use the Uniform Financial Report in order to compute the reimbursement that should go to hospitals for taking care of Blue Cross subscribers also?

A Yes.

Q Was I correct that you had been with Blue

Cross in the reimbursement area for 15 years?

A I went into the reimbursement in May of 1961 and left in August of '75.

Q Will you tell us what you presently are doing?

A I'm a consultant with Ingram & Company, a hospital financial consultant.

Q How many hospitals do you now represent?

A About 40.

Q Do you expect to be paid for your time here today, Mr. Ingram?

A Yes, I do.

THE COURT: The same as you are. I assume people get paid for coming down here.

Go ahead.

Q Are you, as the result of your years with Blue Cross, familiar with the manner in which Medicare payments are made to hospitals?

A I am.

Q Are you familiar with the system called Periodic Interim Payments?

A Yes, I am.

Q Can you tell the Court when that system was first established by the Government, and what the circumstances were?

A The system came into being in 1968. I don't remember precisely during the year when it came in.

I think it was in the spring. It came about as the direct result of the paper work backlog that had developed. You have to go back to almost the night of June 30, 1966 to think of a program that was not in existence and one minute later it was, and a massive program at that.

Virtually everyone in the business, hospitals, the fiscal intermediaries and the Social Security Administration simply had not geared up to handle paper work.

MR. SCHAFFER: I would like to object to this point. A good deal of this testimony is not on the witness' personal knowledge. He is not prepared to testify as to what problems the Medicare Administration was having. He was working for Blue Cross.

THE COURT: Objection overruled. Go ahead.

A Because payments for services rendered were tied to the processing of individual bills, hospitals almost immediately began to develop serious cash flow problems. An attempt in this area was made to solve that with the current financing program. The problem became so acute in this area that an accelerated payment program was introduced which practically doubled the advance under the current financing program, but it was pretty clear to the

intermediary and the Social Security Administration staff that this was not a satisfactory method.

Sometime early in 1968 a staff of members from the Social Security Administration called me. The man's name was Alvin Diamond. He told me that he had--

MR. SCHAFFER: Objection, your Honor. Hearsay.

THE COURT: This is a preliminary injunction. He is just giving me background.

I am completely able to cut out hearsay statements from my mind. There is no jury here. Go ahead.

Q Go ahead.

A Mr. Diamond called me to outline a system of payment that he had developed which would divorce the flow of money from the flow of bills.

He thought this would cure the cash flow problem, and at the same time properly cure the backlog problems because it meant the backlog would be attacked in an orderly fashion rather than under the kinds of pressures that had been developed.

We discussed the method. I think, as I recall, I made several suggestions, and eventually the method came through in an intermediary letter, and in the regulations.

Q Is that system still the system that is being used as of today?

A It is, yes.

Q Would you briefly describe how that system works?

A The fiscal intermediary is instructed to determine, based on prior experience and any other material that the intermediary may have, the amount of the annual payments that will be made to a given provider by the Medicare program.

That amount is divided by 52 and each week a check for an equal amount is sent to the provider. At the end of the calendar year--

THE COURT: This is a calendar year?

THE WITNESS: In New York it is done on a calendar year, your Honor.

Q Go ahead.

A At the end of the calendar year, the hospital submits a financial report. The fiscal intermediary audits the financial report, and a settlement is developed.

That settlement will produce either an additional amount due the hospital or a refund from the hospital to the program depending on the level of the equal weekly payments that are made during the year.

THE COURT: So it is like a post-audit operation, isn't it?

THE WITNESS: Yes, your Honor.

Q When this gentleman from the Social Security Administration called you and told you about the program, did he tell you what the Government's intent was in establishing this program?

Did you discuss that with him?

A Naturally we did. The Government's intent at that time was to eliminate the cash flow problems that the providers were experiencing, and to begin to attack the backlog in some kind of an orderly fashion.

Q What was your personal knowledge at that time of the cash flow problems that the hospitals in the City of New York were having with Medicare?

A Severe, serious and debilitating.

THE COURT: 1968?

THE WITNESS: Yes, your Honor.

Q Will you tell me what your knowledge as of the time you left Blue Cross in August of 1975 is with regard to the cash flow problems of the voluntary hospitals?

A Depending on the location of the hospital within the inner City, depending on the extent of the ambulatory services that the hospitals render, it will range from incredible deficits with serious cash flow problems to a hospital in the more affluent suburbs which is able to manage its affairs on a normal routine basis.

THE COURT: Say that again. Under the present plan there are extreme cash flow problems when they get paid every week?

THE WITNESS: Your Honor, the question directed to me was the general condition of hospitals. Not the effect of the present plan.

THE COURT: I don't care about the general conditions of the hospitals. I want to know what is happening now.

I ask you under the present plan do the hospitals have serious cash flow problems?

THE WITNESS: Not with Medicare beneficiaries, your Honor.

THE COURT: All right.

Q Mr. Ingram, are you familiar with the proposed change in the manner in which the PIP program is to pay hospitals?

A Yes, I am.

THE COURT: You are going to ask him what it means, PIP, aren't you?

The record does not know what PIP is.

MR. IMBERMAN: I am going to put that on the record now, your Honor.

Q When I said PIP, it is an anacronism for Periodic

Interim Payments, and you understand that, and that is the program we have been talking about that the Government instituted in 1968, right?

A Yes, sir.

Q And you are familiar with the proposed change in the method, am I right?

A Yes, sir.

Q What was the principal difference in the two methods?

A The original method provided for an average lag in payments of three and a half days.

Q The method in existence now?

A That's right. The present method, as I understand it, provides for an average lag in payments of 21 days.

Q While you were at Blue Cross, did you ask the staff to make a study for you of the effect which this change in Medicare payments would have on hospitals?

A Yes, I did.

Q Was that study reduced to writing?

A Yes, it was.

Q Do you have it here?

A I have it in my briefcase.

Q Will you get it?

A Yes.

Q Would you be good enough to produce it?

A That is a photocopy of the original one.

MR. IMBERMAN: May I have this marked for identification, your Honor?

(Plaintiffs' Exhibit 1 for identification marked.)

BY MR. IMBERMAN:

Q Mr. Ingram, look at the third page of Plaintiffs' Exhibit 1.

Is there anything on there in your own handwriting?

A Yes, there is.

Q What is that?

A It is the total of the column which multiplies the weekly PIP payment by three. My own handwriting is $35,304,900.

MR. IMBERMAN: Your Honor, I offer that document in evidence.

THE COURT: What is that figure?

THE WITNESS: $35,304,900.

THE COURT: What does that represent?

THE WITNESS: That represents the weekly PIP payment to hospitals in the New York Metropolitan area

multiplied by three.

THE COURT: I understand but I don't know what this figure is supposed to represent. How can I rule on it?

You say that it is a reduction in PIP payment. Does that mean at the end of the year they are going to get $35 million less than they received the prior year?

THE WITNESS: The change from a three and a half day lag to a three week lag will reduce the cash flow to these hospitals by $35 million. Yes, your Honor.

THE COURT: But at the end of the year they will be getting the same amount of money, will they not, as they would have received last year?

THE WITNESS: Yes, they will.

THE COURT: Then I do not understand the figure.

THE WITNESS: It is the timing of the payment.

THE COURT: You put him on the stand as an expert.

THE WITNESS: It is the timing of the payment, your Honor. They will eventually get the same amount of money, but they will get it three weeks later than they would get it ordinarily.

THE COURT: Are you claiming that they will have a constant $35 million deficit?

THE WITNESS: Yes, sir.

THE COURT: Like the City of New York rolling over their notes?

THE WITNESS: In effect, yes, sir. This is something that will occur once and once only, and in a given calendar year will, from a cash standpoint, reduce PIP payments by $35 million.

Eventually the hospital will get this money.

THE COURT: Three weeks later?

THE WITNESS: Three weeks later, yes, sir.

BY MR. IMBERMAN:

Q But always three weeks later, right?

A Yes.

THE COURT: Wait. Wait. In other words, you are saying that the purpose of this document is to show that the hospitals have a continual short term loan of $35 million required by this proposed plan as opposed to what they pay now, if any.

I gather they pay nothing now from what you told me.

MR. IMBERMAN: If your Honor please, I would respectfully object to that statement by your Honor because I do not think that is what it shows.

If I may have a moment.

THE COURT: He is the expert. He is the one under oath. He is the one who is testifying. I rely on him and not on you.

This is a factual matter. You are submitting a document in evidence. I am asking the witness does this mean that the voluntary hospitals, and I gather--incidentally, what area do the hospitals cover for the record?

THE WITNESS: The lower 17 counties of New York, sir.

THE COURT: That includes some in Long Island

THE WITNESS: Yes, sir.

THE COURT: And some will not be in our jurisdiction, but I don't think it makes any difference.

You are saying that they will, in the aggregate, have a $35 million deficit in cash flow which I gather will have to be met by borrowing money.

THE WITNESS: Yes, your Honor.

THE COURT: So they will continually have outstanding $35 million worth of paper.

THE WITNESS: Yes, your Honor. Exactly.

THE COURT: All right. Is there an objection to this document?

MR. SCHAFFER: No, your Honor.

(Plaintiffs' Exhibit 1 received in evidence.)

THE COURT: Now you may proceed, Mr. Imberman.

MR. IMBERMAN: Your Honor, if I may say one thing. That assumes that the hospitals will be able to borrow the money.

THE COURT: That is not the issue, is it?

MR. IMBERMAN: I think it may very well be in some cases, your Honor.

THE COURT: The issue is whether you are going to get reimbursed for your cost.

MR. IMBERMAN: The issue is when. That is most important.

THE COURT: The issue is not whether you are going to be able to borrow $35 million. That is not the issue before this Court.

I am in no position to make that determination and neither is this witness.

MR. IMBERMAN: Of course not but the point I am trying to make, your Honor, is that working capital is a part of the cost.

THE COURT: I understand that fully, but don't tell me there is an issue here of whether they can borrow it in the first place because that is not in issue here because you have nobody here able to tell me whether they can borrow it in the first place. That is not in issue

here because you have nobody here able to tell me whether they can borrow it or not.

You do not know and I do not know.

MR. IMBERMAN: I can put on a fiscal officer from the hospital, and he can tell you.

THE COURT: That it would be impossible to borrow this money?

MR. IMBERMAN: I will let the witness testify in this case.

THE COURT: I won't believe him.

MR. IMBERMAN: All right. If your Honor please, I would like to offer as Plaintiffs' Exhibit 2, a typewritten copy of Exhibit 1 which makes it more legible.

In addition, I would like the record to note that because Exhibit 1, which was prepared by Mr. Ingram, listed some hospitals which are not members of the Greater New York Hospital Association, therefore, technically not members of the class I have shown on Exhibit 2, or my proposed Exhibit 2, the hospitals which are not members of the class.

On the third page we have indicated a subtraction for the amount of money represented by them.

THE COURT: All right. That reduces the figure to twenty-eight million, three hundred and seventy some odd

dollars.

MR. IMBERMAN: For the class, your Honor.

THE COURT: All right. Go ahead.

BY MR. IMBERMAN:

Q Mr. Ingram, from your knowledge of the fiscal condition, the financial condition of hospitals in the greater New York area, can you tell us whether in general they have cash to substitute for this deprivation of working capital?

A Some do. Most don't.

Q Would the proposed new PIP system be easier to administer than the present system?

A There is no difference in the present system as far as the fiscal intermediary is concerned.

Q Is it administratively feasible for Blue Cross to continue to make weekly payments under this system that has been in effect since 1968?

A Of course.

Q Is the cost of working capital a reasonable part of the reasonable cost of running a hospital?

A It is.

Q If any of the voluntary hospitals would have to borrow the money which they would be short if the new PIP system went into effect, how would the interest cost be

borne, by whom?

A The interest cost would be borne by all third-party payers, and by the individuals who pay for the cost of hospitalization out of their own pocket.

Q Who are the major third-party payers of hospital costs in the New York area?

A Medicare, Medicaid, Blue Cross.

Q Taking the voluntary hospitals in the City of New York as a group, approximately what percentage of their costs are borne by those three payers?

A Approximately 85 per cent.

Q Do the voluntary hospitals in the New York Metropolitan area have any way of generating working capital?

A For the most part, no. In order to generate working capital you have to have a function that would generate a profit.

This is one of the purposes of profit, and the possibility that hospitals in the New York area generating a profit in any function are very minimal.

Q Why is that?

A The reimbursement by the major third-party payers is cost based, and does not provide for any margin of profit on top of cost.

That leaves a very small segment of the population on which the hospital is able to generate a profit.

In the middle class of the suburbs, this percentage is somewhat larger than in New York, but in New York it is virtually for all intents and purposes nonexistent.

Q Are there services in which the New York hospitals render on which they lose money?

A The hospitals in the New York area are losing such unbelievable sums of money in rendering ambulatory services as to make the future of hospitals in the New York area a dubious proposition.

Q What is ambulatory?

A Emergency services, clinic services.

THE COURT: You mean outpatient services?

THE WITNESS: Yes, your Honor.

BY MR. IMBERMAN:

Q Does Blue Cross deposit money in advance with the hospitals?

A Yes, Blue Cross has an advanced payment program. The amount that is deposited will vary from 100 per cent of the amount of bills that are in the so-called pipeline, that is in process, down to a lesser percentage depending on entirely how fast a hospital is able to bill.

If the hospital is able to bill quickly, the hospital will have all of its Blue Cross receivables financed.

Q In advance?

THE COURT: I do not understand. What I do not understand is that if they are able to bill quickly, they get their money in advance?

THE WITNESS: The amount of money that they have in adance, your Honor, under the Blue Cross program, and admittedly it is a complicated program, will vary by percentages from 100 per cent down to a lesser amount depending on the hospital's own record of billing Blue Cross.

The Blue Cross staff, including myself, was quite concerned that if the hospitals received an advanced payment program, they would not devote the proper attention to billing for the services that were rendered. Blue Cross being an insurance company essentially has to have those bills on a reasonably fast basis in order to determine whether it is liquid or not.

BY MR. IMBERMAN:

Q Mr. Ingram, on a percentage of the days of Blue Cross payments, approximately what percentages of days, payments in advance, does Blue Cross deposit with the

hospitals, approximately?

A That I would have to make some computations to figure that one out with any degree of precision.

If you want an off the top of the head answer --

Q Give us your best estimate for this purpose.

A The average hospital takes between 30 and 40 days to bill a case from the day the patient is admitted until Blue Cross -- it takes 30 to 40 days for Blue Cross to pay.

If the hospital is doing its part and billing promptly, the hospital will have 40 days of cash on hand. That can vary down to as low as 10 to 15 days, depending again on how fast the hospital bills.

THE COURT: So, therefore, the hospital has the advantage of cash on hand that it really does not need for a period of time.

MR. IMBERMAN: The hospital is spending the time to take care of the patient, your Honor.

THE WITNESS: Exactly.

THE COURT: If they get it in advance --

MR. IMBERMAN: In advance of the bill. In other words, Blue Cross is paying the hospitals in advance of the time that it gets a bill from the hospital, from the subscriber, but in the meantime the hospital has

ms4 Ingram - direct

taken care of the subscriber, your Honor.

BY MR. IMBERMAN:

Q Isn't that so, Mr. Ingram?

A Exactly.

Q And this is a case of Blue Cross furnishing working capital to the hospitals.

A Exactly.

Q Does Blue Cross have a working operation in New York?

A Yes, they do.

Q Do you know how much payment in advance Medicaid gives the hospitals?

A Three months of payments in advance as I understand the system.

THE COURT: This advance payment plan is advance of billing?

THE WITNESS: Exactly, your Honor.

BY MR. IMBERMAN:

Q Is the Medicaid system also a method of providing the hospital with working capital?

A It is.

Q Under the present Medicare system where the hospital is paid according to the HEW intermediary letter with a lag of three days, is that fairly close in your

opinion to have a deposit?

A Taking all the circumstances into consideration, it is, yes.

Q That is giving the hospital a constant cash flow, right?

A A constant cash flow.

Q In your opinion what would happen to the voluntary hospitals and their fiscal situation if instead of getting the constant cash flow with the lag of three days between the time they take care of the patient and the time they receive the money, if that were swithced to a lag of 21 days?

A The hospital would have to find some resource to finance the difference between three and a half days and 21 days.

MR. IMBERMAN: I have no further questions.

THE COURT: All right.

Mr. Schaffer.

CROSS EXAMINATION

BY MR. SCHAFFER:

Q Mr. Ingram, you have testified, have you not, that there was a cash flow problem that the hospitals experienced after the beginning of the Medicare program in 1966, is that correct?

A Yes, sir.

Q Was that cash flow problem due to the conventional reimbursement system which was then being used by Medicare?

A When you say "reimbursement system", do you mean the system for establishing the level of reimbursement or the system for paying hospitals?

Q The hospitals' system for paying hospitals.

A It was the direct result as the system of paying hospitals.

Q You also testified that currently hospitals are suffering from an acute cash flow problem, is that correct?

A That's correct.

Q Is that cash flow problem, that is the current one, due to the system by which hospitals are being reimbursed by Medicare?

A No, it is not.

Q What are some of the factors it is due to?

A The primary factor is the loss that is being incurred by hospitals in rendering ambulatory services.

Q With respect to those ambulatory services, Mr. Ingram, under the present PIP system used for members of plaintiff class, that is under the weekly PIP system,

ms7 Ingram - cross

are ambulatory services covered under the PIP system?

A No, they are not.

Q Sir, in other words, even if the PIP system is changed from weekly to biweekly, that does not affect the rate of reimbursement for ambulatory services, does it?

A No, it does not, that's right.

Q Yet you have testified it is because of the ambulatory services that hospitals are presently suffering, or at least principally because of the ambulatory services that they are suffering your cash flow problem, is that correct?

A Precisely.

Q Your testimony as to cash flow problem, what is the source of your knowledge? Is it the UFR's that you previously spoke about?

A It is the Annual Form Financial Report submitted by each hospital, plus daily ongoing conversations with hospitals in addition to constant demands that were being made on Blue Cross to increase reimbursement to assist with this problem.

Q With respect to the Uniform Financial Report, those are submitted by the hospitals to Blue Cross, is that correct?

A Yes, sir.

ms8 Ingram - cross

Q Are they audited by Blue Cross or accepted as is?

A They are audited by Blue Cross.

Q How often?

A Annually.

Q I believe they are submitted monthly, is that correct?

A No. The reports are submitted annually.

Q And the figures you used in your studies, were they taken from audited UFR's or unaudited reports?

A Unaudited, that is unaudited by Blue Cross.

The Uniform Financial Report is audited by an independent public accounting firm of the hospital's own choice, and the balance sheet from which the current assets and liabilities were taken were audited balance sheets, that is audited by CPA's.

Q On that study you have used the number 3 as your multiplier, is that correct?

A Correct.

Q Why did you choose the number 3?

A It was convenient.

Q What does it represent?

A It represented at the time we made the study the approximate increase in the lag that was going to

take place.

Q I am afraid I do not understand.

Under the modified PIP system the average lag is three days, is that correct?

A Three and a half days.

Q Under the modified system it is three weeks?

A Correct.

Q And under the previous PIP system still in use in certain hospitals, the average lag is three and a half days?

A Correct.

Q Shouldn't the multiplier have been two and a half rather than three?

A Probably. Yes. If I had known at that time that the modified PIP system was going to a three-week lag rather than three and a half -- at the time this sheet was prepared we were uncertain as to the regulations. My reading of the regulations indicated to me that the lag was going to be increased by three weeks rather than a three-week lag.

Q But, in fact, the original notice of proposed rule making change in the PIP system was issued in January of '74, correct?

A Correct.

ms10 Ingram - cross

Q And pursuant to that notice of proposed rule making it was set forth that there would be biweekly payments and payments would be made no earlier than two weeks at the end of the service period, is that correct?

A I don't recall the original issuance period. What prompted me to have this exhibit prepared were regulations that were issued in 1975, I believe, sir.

And my reading them indicated to me that the lag was going to be increased by three weeks. I submit that my reading is wrong, but at least that is the reason for doing it.

THE COURT: Mr. Ingram, you started to indicate for the record what was meant by the 3 times 5 notation on the top of the next to the last column.

What does that mean?

THE WITNESS: Presently hospitals in this area are being paid or were at the time this was prepared, $11,768,300 per week. An increase in the lag of three weeks would be three times that figure, sir.

MR. IMBERMAN: Your Honor, it is three times Column 5.

THE COURT: Oh. Oh.

THE WITNESS: Three times Column 5.

BY MR. SCHAFFER:

Q Mr. Ingram, would it be your testimony now that for a correct computation of the amount of cash flow lost by the hospitals, the multiplier 2-1/2 should have been used rather than 3?

A It should be computed on the basis of days. The lag goes from 3-1/2 to 21 days, a 17-1/2 increase in the lag. We could reduce this to a per diem cash flow and multiply it by 17-1/2.

Q If the difference in time is three and a half days to three weeks, isn't that a change of two and a half weeks?

A It would well be.

Q How can it be anything else?

A Mr. Schaffer, I'm the kind of person that I would not tell you today was Tuesday until I looked at the calendar.

If you give me the opportunity to work it out mathematically, I'll be glad to do it.

Q I'm not a mathematician but isn't it clear when you subtract 3-1/2 days from three weeks you get two and a half weeks?

MR. IMBERMAN: Your Honor, I would be willing to concede that this total amount is off. I do not think

msl2 Ingram - cross

there is any point in Mr. Schaffer arguing with Mr. INgram.

The Government's own intermediary letter says:

"Under the old system a lag of three days and under the new system a lag of three weeks."

I will be willing to compute what the lag was and work out the computation.

THE COURT: It doesn' make much difference. Unless your point is that the lag is going to be so greatly reduced as the result of the computation that the hospitals can clearly take care of the cash problem.

MR. SCHAFFER: The point is the $35 million figure overstates by one-sixth, one-sixth being one-half of three.

THE COURT: All right.

BY MR. SCHAFFER:

Q After taking into account that some of the hospitals on your list are not members of the plaintiff class that Plaintiffs' Exhibit 2 indicates, the loss of cash flow is $28 million --

THE COURT: Plaintiffs' Exhibit 2?

MR. SCHAFFER: Marked for identification. I don't know if it was introduced.

THE COURT: I thought it was substituted. There is only one exhibit.

msl3 Ingram - cross

MR. IMBERMAN: The typewritten copy being Exhibit 1.

BY MR. SCHAFFER:

Q In any event, the typewritten copy, Exhibit 1, taking into account that it is overstated by one-sixth but we will use the number here of $28 million as the loss of cash flow.

Now, approximately what is the total Medicare reimbursement to the New York area hospitals in a given year currently?

A Approximately $650 million.

Q So of that $650 million we have a loss of cash flow of something less than $28 million?

A Correct.

Q You stated that the current cash flow problem was caused by factors other than the Medicare payment system or the timing of the Medicare payment system.

Because of those cash flow problems, have hospitals in the New York area had to borrowing to meet their current capital needs?

A Yes, sir.

Q Where they can show that that borrowing is necessary for operating expenses, is it not true that Medicare reimburses them a percentage of the interest cost?

A Yes, sir.

Q And Medicare does that even though the borrowing was not made necessary or not precipitated by anything having to do with the Medicare program, isn't that correct?

MR. IMBERMAN: If your Honor please, I object to the form of that question.

THE COURT: He is asking whether it is true or not. He can say yes or no.

A It is true.

Q It is true that when Medicare reimburses for interest cost it just looks to see whether there was a general need, not the specific borrowing, is that correct?

A Exactly.

Q You have stated that there is an average lag of 30 to 40 days between the time that a patient leaves the hospital and the time that a hospital, Blue Cross generates a check to the hospital under the Blue Cross system.

A From the time the patient is admitted to the hospital to the time that Blue Cross pays it will range between 30 and 40 days. Probably closer to 40 than 30.

Q When we are talking about Blue Cross we are talking about Blue Cross in the capacity as a private

msl5 Ingram - cross

insurance carrier, is that correct?

A Yes, sir.

Q So that hospitals under the private Blue Cross system are encountering a lag of approximately 40 days, is that correct?

A That's correct.

THE COURT: What is this?

MR. SCHAFFER: The witness has testified, your Honor, that the lag between the time that a patient enters the hospital and the time that Blue Cross generates a check under private Blue Cross insurance is approximately 40 days.

The witness has said that that is the lag in payment.

THE WITNESS: No, that's the lag in pay ing for a specific case.

BY MR. SCHAFFER:

Q What is the average length of stay in the hospital?

THE COURT: Wait. Wait. Wait. I thought there was a prepayment plan before the bill came in so there isn't the 30 to 40-day lag.

MR. SCHAFFER: What I am trying to point out is, and putting aside for the moment the issue of the prepayment,

ms16 Ingram - cross

that the system of generating payments of Blue Cross is, in fact, slower than the proposed three-week lag in the PIP system.

THE COURT: It is not, in fact, slower because it is a prepayment.

MR. IMBERMAN: Exactly.

THE COURT: Theoretically it would be, but in order to meet that they have a prepayment system.

MR. SCHAFFER: Of course.

THE COURT: So there is no 30 or 40-day lag.

Ask him if there is a lag with the prepayment system, because it is not a lag of prepayment of services but the billing.

THE WITNESS: Correct, your Honor.

THE COURT: How much lag is there now even with the prepayment treatment between the renditon of the service on Friday, November 28th, and the hospital getting paid for that? Even under the prepayment system there has to be a lag.

THE WITNESS: It will range from zero to, perhaps, as high as 50 per cent.

THE COURT: 50 per cent of what?

THE WITNESS: Of the cost.

THE COURT: I am talking about the day of

ms17 Ingram - cross

payment. A patient comes into your hospital today, November 28th, a member hospital, and he is treated for a broken leg.

How long does the hospital have to wait to get money for today's treatment even under your prepayment plan?

THE WITNESS: In those terms, your Honor, it will range from zero days to approximately 20.

BY MR. SCHAFFER:

Q So it is an average of 10 days because we are doing averages here, aren't we?

MR. IMBERMAN: I am not prepared to accept that it will be an average because we don't know how many days are zero and in between.

THE COUFT: It is obvious, Mr. Imberman, that there is a lag even under the prepayment plan. There is a lag.

They are not getting paid today for fixing my broken leg today.

MR. IMBERMAN: If the hospital gets 40 days' payment in advance, 40 days of Blue Cross billing, and has that on deposit, I would submit that the lag for any individual patient would be minimal.

But I have a group of fiscal officers from the hospital, your Honor.

ms18 Ingram - cross

THE COURT: He is the expert of Blue Cross

MR. IMBERMAN: I have other witnesses.

THE COURT: We will get to them. I want to get this witness" testimony.

THE WITNESS: The Blue Cross method is an incentive method. The faster the hospital bills, the more money it will have on deposit.

In actual practice what happens is if a hospital is affluent, it does not break its neck to get the bills in. A hospital under fiscal pressure will really do a job in the billing department, and get the bills in quickly.

As the direct result of that, the amount of cash advance is larger. In many cases it does completely cover the cost of services being rendered on the day of service.

THE COURT: Now you have to explain this prepayment plan more in detail because I don't understand it.

Let's assume a hospital opens December 1st, 1975, opens its doors for business. Explain to me how your system works.

THE WITNESS: For that kind of a hospital we would use the average experience of other hospitals. But if I may take a hospital already in business, what

ms19 Ingram - cross

Blue Cross did was to determine what the annual payments would be, and would say to a hospital, "We will make an advance payment to you based upon a percentage of the annual payment. If your billing is more than 30 days, if the lag in your billing, from the time the patient is discharged until the time the patient gets the bill", and they have computer runs to determine this, your Honor, "We will not give you any kind of an advance payment because you do not need one."

And, "By your own laxity in billing there will be no advance payment."

However, if the lag is only for five days from the time of discharge to the time that Blue Cross receives the bill, and this was determined to be about as short a time as the hospital could conceivably do it, they will have to deposit. I believe the current figure is 11 per cent of annual payment.

Now, the percentages would range anywhere from zero, 1, 2, 3, 4, 5 depending on the time lag in the billing, and the percentages which are designed so that at no point would Blue Cross have on deposit with a hospital more than the cost of the day's care. The reason for that is the insurance law in New York.

However, it was designed very carefully so that

the figure could and did go right up to 100 per cent.

THE COURT: But there still would be five days of lag, wouldn't there?

THE WITNESS: No, your Honor, there wouldn't. The hospital would have that money in the bank and would cover the day of service it would render. There might be a five-day lag in the billing, but that was a measure of the mechanical time it took to prepare a bill.

THE COURT: But your money did not go out until you got the five-day bill, did it?

THE WITNESS: The money for that bill did not, but the deposit was there at any given time.

THE COURT: In other words, take the theoretical hospital that opens on December 1st. Would you give them a deposit on patients they are going to treat during the month of December?

THE WITNESS: Yes, we would, your Honor. We have to determine --

THE COURT: I assume you would take last year's billing for a comparable hospital and say, "We will give you you 1/52" or whatever it is, and that is the way I understand the present PIP plan works.

THE WITNESS: Yes, Your Honor, we would. We would put on deposit with them just as a security rent

deposit that a tenant would make with a landlord.

THE COURT: All right. I think I understand.

Go ahead.

BY MR. SCHAFFER:

Q Mr. Ingram, let me pursue this. In this situation where a hospital is very efficient in getting its billing out and, therefore, has on deposit 100 per cent of its expenses for a given day, then the only lag between the time of delivery of service and the time it actually gets the money would depend on how long that patient was in the hospital, is that correct?

A No. Actually the hospital has the money for that patient while the service is being rendered, and has it there constantly on an average.

Q Therefore, a hospital that is very efficient would be one which had zero lag between the delivery of service and the time of payment.

A Exactly. Exactly.

Q I want to make sure that it is possible to have no lag at all.

A Yes.

Q Hospitals that are less efficient in their billing practices, you have testified, might suffer up to a 20-day lag.

A Exactly.

Q And the lag we are talking about is the lag from the date the service is delivered to the date the payment is made, is that correct?

A 20 days. It can go 40 days or more.

MR. SCHAFFER: I ask the Court's indulgence, but this may open up another can of worms.

THE COURT: We have plenty of worms already.

BY MR. SCHAFFER:

Q Is the prepaid system under Medicaid basically the same you have described under Blue Cross?

A I'm not completely familiar with the Medicaid system. It is my understanding they have estimated the monthly volume with the hospital, and put up three months in advance with hospitals. That's about the extent of my knowledge, Mr. Schaffer.

Q Would you be able to venture an opinion as to whether the average lag, even with prepayment under the Medicaid system, is greater or lesser than under Blue Cross?

I realize I may be asking you whether New York City is more or less efficient than your former employer, but that is the gist of it.

A I have no way of knowing.

ms23 Ingram - cross

Q Mr. Ingram, how often do New York area hospitals have to pay wages and salaries?

A It will vary. There are weekly payrolls, bi-weekly, monthly payrolls.

Q Would you say that most employees get paid bi-weekly?

A As I understand it the union employees get paid weekly, and the union is fairly strong in this area, and nurses probably every two weeks, professional rank will get paid monthly.

Q Who are the union employees?

A Primarily housekeeping, laundry and linen, clerical people, to some extent technical people, and in some hospitals practical nurses, orderlies, aids.

Q Can you estimate what percentage of the total payroll obligation of the New York Hospitals goes to union employees?

A No, I can't, sir.

Q Can you estimate what percentage of the total number of employees are non-union employees?

A No. Of my own knowledge I can't.

Q Is it fair to say by and large the union employees are the lower paid employees?

A Yes, it is.

ms24 Ingram - cross

Q One other matter on salaries, about what percentage of a hospital's current expenses are taken up in salaries and wages?

A In direct salaries approximately 62 per cent.

Q You say direct salaries. What does that phrase mean?

A Fringe benefits would add another 10 per cent to that.

Q And would the remaining percentages of current expenses be payment to vendors for various goods and services?

A Except for the depreciation cost, yes.

Q Do hospitals generally pay vendors immediately upon receiving the services or goods that are being purchased?

A No, they do not.

Q About how long is the lag?

A The average lag is in the New York area is 60 days.

Q In fact doesn't the lag sometimes become much longer than that?

A Oh, yes, it does.

Q How long will it get to be?

A I heard of lags as long as nine months.

Q You have testified, I believe, that in your opinion the loss of cash flow that would be occasioned by the changeover to a modified PIP system would require most of the hospitals and plaintiff class to engage in some borrowing, is that correct?

A I believe so, yes, sir.

Q Do you have an opinion as to what percentage of that loss cash would have to be paid up in the form of borrowing?

A I haven't made the study, no. I would say it may run as high as half.

Q So that if we use the 28 million-dollar figure again, keeping in mind that the Government has an objection to that figure, approximately $14 million would have to be borrowed?

A It might go that high, yes.

Q Do you have any knowledge as to what percentage of the total current liabilities of the New York area hospitals such borrowing would represent?

A No, I have no idea.

MR. SCHAFFER: No further questions, your Honor.

THE COURT: May I ask you a question, Mr. Ingram?

THE WITNESS: Yes, your Honor.

THE COURT: You have this figure of $28 million on Column 6. If there is no need to make borrowings for the present PIP payments which according to this shows $9,457,000, you are assuming that it is the impact of the extension that creates the borrowing.

THE WITNESS: Yes, your Honor.

THE COURT: Therefore, shouldn't the $9 million be taken out of the $28 million because $9 million of it you do not need to borrow?

You only need to borrow for the impact which would be the $18 million or $19 million dollars.

THE WITNESS: If the lag were properly 21 days, properly, the impact would be $28 million, your Honor, because the lag is being increased.

Actually the lag is 17-1/2 days, your Honor, and the time lag from 3-1/2 days to 21 days which means that 17-1/2 days of PIP payments will have to be financed by some hospitals.

THE COURT: But if you do not have to finance your payments now, shouldn't that, to the extent that you don't have to finance your payments now, shouldn't that be subtracted?

THE WITNESS: Not from the increase in the

lag, your Honor.

THE COURT: Okay.

REDIRECT EXAMINATION

BY IMBERMAN:

Q Mr. Ingram, you were talking about Medicare and ambulatory services at the beginning of your cross-examination.

Does Medicare pay for some portion of the ambulatory services?

A Yes, it does.

Q How long does the hospital have to wait for that money?

A Of my own knowledge I couldn't tell you. It depends how long the hospital gets the bill and how long it takes to process the bill.

Q You don't have a specific answer?

A No, I do not.

Q On your cross-examination you said that the total amount of Medicare annual payments in this area was $650 million.

A Approximately.

Q Is that for all the hospitals in the 17-county area?

A Yes, it is.

No, I am sorry. Let me correct that.

It is for the 140 hospitals that have chosen Blue Cross as their fiscal intermediary.

Q And the members of the class which are members of the Greater New York Hospital Association are being paid under the present PIP system, it would be considerably less than that, would it not?

A It would, yes.

Q Do you have any idea what the annual amount for t[illegible]people is?

A No.

Q But it would be less?

A Yes.

Q Substantially less?

A Substantially less, yes.

Q Mr. Schaffer asked you whether when a hospital borrows money in the ordinary course of its business, whether Medicare pays a portion of that, of the interest cost. Your answer was in the affirmative, am I right?

A Correct.

Q Is that because the interest cost is an ordinary cost in running the hospital?

A Under the regulations interest is an allowable cost.

Q Just as paying for nurses, food or drugs, am I right?

A Yes, sir.

Q And Medicare pays a percentage of the total operating cost based on the regulations which include how many patient days in the extensive use of Medicare patients, am I right?

A Correct, sir. Roughly.

Q There was quite a discussion on cross examination about the system of Blue Cross making deposits in the hospitals.

Could you give us a figure as to what the total amount Blue Cross has on deposit with the hospitals with which it has contractors?

A The last figure I remember, and this was August, was $72 million.

Q $72 million?

A Yes, sir.

Q And this is distributed among the various hospitals that they keep on deposit at all times, am I right?

A Yes, sir.

Q And that is for use as working capital?

A Yes, sir.

Q Are there any hospitals in the Greater New York Hospital Association that have the maximum on deposit with you?

A Yes.

Q Which would be?

A Quite a few.

Q Which would be 11 per cent of the total annual billings?

A Yes, sir.

Q You also testified on cross-examination that based on your knowledge the lag in paying vendors was about 60 days?

A Yes, sir.

Q 60 days from the time they received merchandise or services they paid for it?

A Yes, sir.

Q You also said in some cases the lag could go up as much as six months or nine months, I think you said.

A Yes, sir.

Q Do you know why that is?

A They don't have the money to pay their bills, a form of borrowing is borrowing from vendors.

Q The vendor is the banker instead of the bank?

A Exactly.

Q Do you know the effect that has on the hospitals?

A It raises the price.

Q Would the change in the PIP trip system to what the Government is proposing now make the working capital situation of the hospitals better or worse?

A In my opinion, sir, worse.

Q Are there some hospitals to your knowledge which cannot borrow money now because they have exceeded their borrowing ability?

A There are, sir.

MR. IMBERMAN: I have no further questions.

THE COURT: You may step down.

(Witness excused.)

THE COURT: You may call your next witness.

MR. IMBERMAN: Mr. Birnbaum.

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I R W I N B I R N B A U M , called as a witness, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. IMBERMAN:

Q Mr. Birnbaum, where do you live?

A 49 Palmer Avenue, Scarsdale, New York.

Q What is your occupation?

A Deputy director for fiscal affairs of Montefiore Hospital Medical Center.

Q Will you give the Court your educational background?

THE COURT: You do not need that, do you, Mr. Schaffer?

MR. SCHAFFER: No, your Honor, we will stipulate as to his qualifications.

MR. IMBERMAN: I assume you are stipulating to his qualifications as a fiscal expert in hospital administration.

THE COURT: He is the deputy director for fiscal affairs of Montefiore Hospital, and as such he is testifying.

BY MR. IMBERMAN:

Q How long have you held that position?

A Since 1969.

Q How long have you been in hospital administration

generally?

A Since 1963.

Q Are you familiar with the manner in which hospitals are reimbursed for services rendered to Medicare patients?

A Yes, sir.

Q Could you briefly tell the Judge for the record the manner in which the reimbursement for services rendered to Medicare patients is computed under the regulations?

A The Medicare costs are divided into two areas, your Honor. What they call routine costs and ancillary costs.

The routine costs are those what we call in the field the hotel services, housekeeping, engineering, dietary, in addition to nursing services which are included as routine as well as the teaching courses, the interns, residents and supervision thereof.

The other group would be the cost of rendering services in the operating rooms, laboratories, and those are the ancillary costs, and x-ray.

The Medicare program reimburses the hospital on the basis of the Medicare days, total days. If 40 per cent are Medicare, they will pick up 40 per cent of the routine costs. On the other hand, the ancillary costs,

the laboratory, the x-ray, since the Medicare statute req3uires that Medicare will pay its fair share, only the belief in Congress at the time was that a Medicare patient, because he was older and stayed lo nger, might use less of the ancillary than a non-Medicare patient. They came up with an approach called the ratio of cost-to-cost applied to charges which is a CCRC. Under that calculation what happens is that the total costs of a department like the laboratory are divided between Medicare, and all other parties on the basis of the amount of Medicare charges to total charges.

To give an example, if an x-ray department costs $1 million, and there were a million dollars in charges that went to all patients, if Medicare represented 30 per cent -- Medicare patients represented 30 per cent of those charges, then Medicare would pick up 30 per cent of the cost of the x-ray department regardless of how many patient days, what the percentage was in terms of patient cays. The two figures added together, and they come up with a total amount of money due to a hospital for rendering Medicare services.

Q How large is Montefiore Hospital?

A In excess of 1300 beds.

Q Is Montefiore the largest provider of Medicare

services in the country?

A Yes, we provide in excess of 250,000 patient Medicare days per year.

Q What area does Montefiore serve?

A The Bronx, lower Westchester, but because of many of our programs, it is an internationally known hospital.

We have had people from all over the world as patients as Montefiore, but primarily the Bronx and lower Westchester.

Q Are you familiar with the PIP system as it was described by the witness who preceded you?

A Yes, sir.

Q You were in the courtroom when Mr. Ingram testified, right?

A Yes, I was.

Q Does Montefiore receive payments under the PIP system now?

A Yes, we do.

Q How much does Montefiore get weekly?

A $889,100. Which I might add greater than the figure there because of the fact that as more and more patients come in, as Medicare and costs go up, that figure becomes adjusted, and the total amount of money is well

in excess of $35 million.

The last figure I got in speaking to people at Blue Cross is that currently Blue Cross pays out almost $12,200,000 a week as of eight or nine days ago. And so that the figure keeps on going up.

I believe the figure on that exhibit is $850,000. It is now $889,800 a week.

Q To what extent does the hospital rely on that?

A Without it I would have to substitute the money, either through borrowing or withholding from vendors.

Q Are you familiar with the proposed change in the PIP system?

A Yes, I am.

Q When did you first hear about it?

A When it was published. I believe January 6, 1974 it appeared in the Federal Register.

Q Did you, on behalf of Montefiore Hospital or Dr. Cherkasky, the executive director, have communication with people in Washington concerning the change in the system?

A I prepared a letter for Dr. Cherkasky's signature which went out to the New York delegation and our two senators and also Senator Kennedy who had an interest, I believe, at the Senate Finance Committee

having to do with health.

Q Did you some time in 1974 have a telephonic communication with somebody at the Social Security Administration about the proposed change in the PIP system?

A Yes, I did.

Q Who did you talk to?

A Mr. Paul Bowers. I don't know what his position at Social Security is, but at that time Congressman Ogden Reid, in response to the letters that I had sent on Dr. Cherkasky's behalf, we got a response from Congressman Reid. He said that the person who is working on the regulations with Mr. Bowers, and the letter we sent he had thought was a good one, this was Mr. Bowers, and if I wanted to have further conversation about the status of the regulations to, perhaps, give Mr. Bowers some direct input as to what this would do to hospitals, that I should call Mr. Bowers.

Q Did you call Mr. Bowers?

A I did.

Q Tell the Court what you said to him and what he said to you about this change in regulation.

A I was somewhat perplexed and tried to understand the reasoning for the change in the PIP regulations since as was pointed out by Mr. Ingram and you, Mr. Imberman, that

under the regulation the one precept that the Congress had in mind would be the hospitals would be paid most administratively feasible, and weekly PIP had done something to clear up the backlog that we were living under in 1967 and 1968.

I said that I could not understand why. He said that all they're doing is going to create a one-time influx of cash into the Federal Government and nothing will happen, and the Federal Government will get, I think, from New York $36 million dollars, and I don't know what it would be nationwide. It would look good on the Government's books for that fiscal year, but hospitals will go out and borrow the money at interest rates greater that that which the Government has to pay.

Adding what I consider to be the socially desctructive costs, and that interest cost, and he said, "You are absolutely right, but the Government wants this for its budgetary purposes by June 30th."

At that time it was 1974. By June 30th -- and to show a more favorable cash flow and a reduction of cash outgo in the Medicare program. I would only note in passing that the current regulations -- it is interesting to note that they make sure that they get all their money back in this curren. fiscal year. No spread out beyond

May 24th of this year. He said that that was the reasoning that was going into the promulgation.

Q Did you have any further conversation with Mr. Bowers about this reason for making the change?

A Well, it was interesting. I think I had the sympathy of Mr. Bowers, but, again, he was only one person. And, as he said, the regulations have to travel through 100 people beyond him, but he felt that the direction that had come down from up on high was that the Government needed this cash flow back to them.

MR. IMBERMAN: Your Honor, I would like to offer this photographic copy of a letter from Congressman Reid, dated April 23rd, 1974.

THE COURT: No, you cannot cross-examine a letter.

BY MR. IMBERMAN:

Q Mr. Birnbaum, what will be the effect on Montefiore Hospital if this new regulation goes into effect?

A If the new regulation gods into effect, if on this coming Monday I do not get the check for $889,100, I have made arrangements to borrow $890,000 -- actually $900,000 to cover that payment.

THE COURT: Why $900,000?

THE WITNESS: Banks don't like -- they like to round it off.

THE COURT: Why do you have to borrow the whole thing?

THE WITNESS: Because I will need that amount of money. The argument going on before about 17-1/2 days or 21 days is picking up the wrong end of it. In fact, three weeks -- I will have three weeks of cash reduced between now and May 24, 1976. When I say I, I mean Montefiore Hospital.

I would normally, if the PIP system were not being changed, on Monday the messenger from Montefiore Hospital would pick up a check for $889,100, and I will deposit it in the bank and use it to pay payroll, vendors and what-have-you.

If that money does not come in -- I work so close I would have to stop paying vendors which I cannot do, or go out and borrow money and make up for that money. It is not 17-1/2 days. It is three weeks of cash.

In the case of Montefiore Hospital $2,600,000 less cash that I will receive between Monday and May 24, 1976 which I have to replace.

I don't make a profit. Montefiore Hospital is a voluntary institution, and it is difficult to make a

profit. The individual case of Montefiore hospital is that close to 90 per cent of the patient care we render is given to Medicare, Medicaid and Blue Cross subscribers. They have not recognized working capital as a cost. Blue Cross and Medicaid have come up with a system to institute for that. Money on deposit.

Medicare came up with a different system called PIP. It worked fine. I would point out that PIP only includes inpatient costs. I have a 120-day lag on ambulatory services. I would estimate that Medicare at any point and time owes Montefiore Hospital cloes to $1 million for care rendered in the outpatient and emergency room. I have to go out and replace that money. It is money that I expect and just like the corner grocery store or any other business, if money that you normally expect does not come in, you have to replace the money. I have to borrow $900,000 on Monday.

THE COURT: Go ahead.

BY MR. IMBERMAN:

Q Mr. Birnbaum, you said on Monday you would send somebody to pick up the check.

A Yes.

Q Do you mean you send somebody down to Blue Cross to pick up the check?

A We send somebody down to Blue Cross on a daily basis. On Monday he picks up the PIP check and that gets the money flowing into our system.

Q One or two days makes that much difference?

A Absolutely.

Q Who would bear the cost if you borrowed that $900,000? Who would pay the interest?

A Interest would be paid by all -- as Mr. Ingram pointed out, by the three major third parties in the proportion that their days were the total days.

In my hospital Medicare pays for 45 per cent of that cost, Blue Cross pays for 30 per cent and Medicaid would pick up 15 per cent. That's 90 per cent.

Q And the balance?

A The balance would be by commercial insurance, union, pension plans, workmen's compensation, et cetera.

Q You said you have made arrangements to borrow the $900,000. Under the Pip plan, by the new proposed PIP plan, by the end of May of 1976 you would be short an additional $1,600,000, am I right?

A Yes, sir.

Q Because every week after December 1st under the plan they give you a certain amount less than you should get?

A Yes, sir.

Q What arrangements have you made to substitute for that shortage of working capital?

A I have made no specific arrangements. The money I will be borrowing on Monday, if I don't get the PIP check, I will be paying an interest rate of 1 per cent over the prime rate.

I have made arrangements for additional money, but that has to do with the New York fiscal situation.

THE COURT: Let's not get into that.

BY MR. IMBERMAN:

Q Go on.

A While I have made arrangements for additional borrowing from banks, it is not having to do with the PIP, we now owe banks $2 million approximately. I have arrangements to borrow another million or so, but only in relation to what might happen in the city. I have to make arrangements to borrow that other $1,600,000.

Q Suppose you can't borrow it, what would happen?

A We would have to reduce the payments to vendors and, I believe, begin to cut back our programs.

THE COURT: This would be Government guaranteed borrowing, wouldn't it?

THE WITNESS: In terms of the receivable, yes,

your Honor, but to the extent that a bank would be willing --

THE COURT: Just earmark your interest from the Government, and don't tell me you cannot borrow the money based on that.

THE WITNESS: What you are doing is going and saying that you want the banker to invest working capital.

THE COURT: Repayment in three weeks from now by the United States Government.

THE WITNESS: On a constantly revolving basis.

THE COURT: Don't tell me you could not find a banker to lend you the money on that basis. This particular borrowing is guaranteed by the United States Government, a payment in three weeks. You can borrow from any bank in the city, but you have to put up the checks. That is what we are talking about here.

This money does not go into your general pot, this is for taking care of Meeicare patients. Therefore, you borrow for the lag, and you put up the payments. Every bank in the City of New York will lend it to you.

BY MR. IMBERMAN:

Q Mr. Birnbaum, does the money go into your general pot?

THE COURT: I don't care where it goes, but we

are talking about a specific problem and that is their burden to pay.

Do not tell me you cannot borrow money that they cause you to borrow through their repayments.

MR. IMBERMAN: The bank may have other loans and there are limitations.

THE COURT: That is not their fault. You are charging them for delaying payment to you so do not throw them into the general pot.

MR. IMBERMAN: It is one situation.

THE COURT: You cannot charge them on one hand and take it away from them on the other. You are charging them with delaying payments. I say yes, if their payments are delayed, they may have to go out and borrow, but that borrowing is against the repayment from them.

I have to keep in that category, and not the general pot. That is your lawsuit. If they need money from something else, it is not Medicare's fault. Maybe somebody else's fault. I don't know whose fault it can be. You say you get everything back from Medicare and Medicaid three months in advance.

I don't see what the problem is except they are holding you off for three weeks.

MR. IMBERMAN: Because the hospitals are losing

money on a multitude of things that they supply to the public at a loss. They are voluntary hospitals.

THE COURT: I understand that, but I gather at the end of the year they get repaid all the maintenance costs, is that true or not?

THE WITNESS: Yes, your Honor, yes.

THE COURT: You don't make a penny on 90 per cent of your patients? Do you lose money on those 90 per cent that Blue Cross pays for or Medicaid or Medicare pays for?

THE WITNESS: Possibly under the reimbursement system in New York there is a possibility that you could.

THE COURT: Go ahead.

MR. IMBERMAN: Your Honor, I might say this. There are many quarrels between Blue Cross and the hospitals as to whether the reimbursement rate is sufficient, and quarrels between Medicaid.

This is a complicated matter, and has nothing to do with this lawsuit.

THE COURT: All we are worrying about is the burden you are claiming the Government is putting on you by stretching out the payments.

BY MR. IMBERMAN:

Q Mr. Birnbaum, is working capital an element of

the cost of running your hospital?

A Yes, it is.

Q Can you tell me the amount of the Blue Cross deposit with Montefiore Hospital in relation to days of Blue Cross service?

A We are one of the hospitals that gets the highest deposit from Blue Cross, a 40-day deposit.

Q How much does it amount to in dollars?

A Two and a quarter -- two and a half million dollars.

Q When you say 40 days, you mean that sum is equivalent to 40 days of billing of Blue Cross?

A Correct.

Q What about Medicaid?

A Medicaid is 90 days, but the difference between 40 and 90, there is a reason for it.

If I can take the Court's time --

THE COURT: It is not important.

THE WITNESS: It is 90 days and about the same amount of money.

BY MR. IMBERMAN:

Q 90 days of medicaid billing you have on deposit with you?

A Yes. Again, in our case two and a quarter

million dollars.

Q Mr. Birnbaum, if you had to borrow money from the bank to make up this cash flow loss, would you be able to to repay it?

A No. When Montefiore Hospital ceased doing business they would be able to repay it because then the three-week lag would be made up, but in the ordinary course of business, I'm asking the bank to invest working capital in to Montefiore Hospital.

Q On a permanent basis?

A On an essentially permanent basis.

MR. IMBERMAN: I have no further questions.

THE COURT: We will have a short recess.

(Recess.)

THE COURT: You may proceed.

BY MR. IMBERMAN:

Q Mr. Birnbaum, do you borrow moneys from the bank now?

A Yes, we do.

Q And you have been borrowing before the notification of the change in PIP?

A Yes, sir.

Q And banks get copies of financial statements?

A Yes, sir.

Q Including statements which indicate where your moneys come from?

A Yes, sir.

Q To what extent do the banks take into consideration, to your knowledge, when they lend you money the amount of your regular flow of cash from these third-party payers?

A Banks have told me the fact that we have such a high percentage of Medicare patients and the money is quote coming from the Government, unquote, that is one of the reasons I am able to borrow, whereas another hospital may not be able to borrow.

Q Is that one of the reasons you have been able to borrow money now?

A Yes, sir.

Q They have taken into consideration the fact that you have money coming from the Government?

A It seems so to me.

THE COURT: They will still lend him more as long as they know the Government is going to pay him in two weeks.

MR. IMBERMAN: I am not at all sure of that, your HOnor.

THE COURT: If they are not going to pay, we

might as well leave and go to Mars or something.

MR. IMBERMAN: One other question, your Honor.

THE COURT: Go ahead.

BY MR. IMBERMAN:

Q You testified earlier than there were costs which were -- you did not get reimbursements for costs of the hospital.

Are there areas in your emergency room and clinics that you do not get reimbursed for that the hospital operates at a loss?

A Yes, the ones you mentioned we operate at a significant loss.

Q What is the significance?

A In our hospital for 1974 I believe the figure was about one million-three after -- $1,300,000 after a -- this was from the City and State of New York of about a million-two, and some which is now in question, so that the gross deficit, two and a half million dollars, adn the net deficit after the money we got with the program with the City and State was three. That program is still in question.

Q Are there some internal costs aside from ambulatory costs that you are not reimbursed for because of the different ways the third-party payers calculate

costs?

A Yes. As I mentioned before, Medicare has taken the hospital costs and put them into routine and ancillary.

The other third-parties have not. They pay the total cost of the hospital, their share of the total cost depending upon the number of patient days. Medicare is 15 per cent of patient days, 15 per cent of the cost, and Blue Cross is 30 per cent. They pick up 30 per cent. However, as I mentioned before, with this principal of RCCAC, Medicare picks up less than the total cost of the ancillary areas which means if Medicare is using less, somebody is using more. In my case Blue Cross or Medicare patients.

Since these two parties only pay on the basis of -- if you would think of total cost as a pie. There is a piece of pie left for me to eat or it falls on the floor and nobody can eat it, but nobody is paying the cost.

THE COURT: But it is not the Government the Medicare's fault.

THE WITNESS: To the extent that they have promulgated the RCCAC it is their fault. To the extent that the other parties will pick it up, it is not their

fault, your Honor.

MR. IMBERMAN: I have no further questions.

THE COURT: Mr. Schaffer.

CROSS EXAMINATION

BY MR. SCHAFFER:

Q Mr. Birnbaum, as part of the cost of a loan, the cost that Medicare reimburses Montefiore Hospital, are there also included interest costs?

A Yes, sir.

Q And are these interest costs reimbursed according to fairly complicated Medicare formula similar to to the one you have described for routine and ancillary cost?

A They would be considered a routine cost and Medicare would pick up in the case of Montefiore Hospital 35 per cent of those costs.

THE COURT: This is considered a routine cost, right?

THE WITNESS: Yes, sir.

THE COURT: That means that since they have 45 per cent of the patient days --

THE WITNESS: They will pick up 45 per cent of the cost, yes, sir.

BY MR. SCHAFFER:

Q It is true, is it not, that Medicare will reimburse you for interest costs as long as they are necessary and without regard to the particular events that precipitated the need to borrow, isn't it?

A They have never been questioned heretofore, yes, sir.

THE COURT: Are you saying or trying to say that Medicare is now picking up some of that interest costs that may be the 10 per cent not attributed to Medicaid and Blue Cross?

MR. SCHAFFER: Not that item, your Honor, but what we are driving at is in the past there has been cash flow problems not attributable to the Medicare timing of payment.

BY MR. SCHAFFER:

Q After those times, it is true, is it not, Mr. Birnbaum, that the hospitals like Montefiore had to go out and borrow money?

A Correct.

Q And also true that Medicare has reimbursed its percentages of the interest costs even though the need for borrowings came from other causes?

A That's correct.

Q Mr. Birnbaum, you have testified that if the modified PIP system goes into effect Montefiore Hospital will go out and have to borrow to make up for the loss of cash flow, is that correct?

A At least what I call the first cut, the first week that is withheld, yes, sir.

THE COURT: But then you get paid the second week, don't you?

THE WITNESS: Yes, sir.

THE COURT: So you pay back the bank.

THE WITNESS: And then have to go out and borrow.

THE COURT: For next week.

THE WITNESS: The next week again. In actual fact what will happen is that we will borrow the money and never repay it because the bank does not want to go through that.

THE COURT: You borrow for a week and you repay it and you wait a week and borrow again if I understand the routine.

What you are really fighting over here is that in May of next year when you all aggregate it -- it is the aggregate at that point.

THE WITNESS: Absolutely, your Honor.

MR. SCHAFFER: Let me pursue this point further, your Honor.

BY MR. SCHAFFER:

Q It is true then that the cash flow difficulty that the hospital may experience due to the change in the PIP system is a problem between now and May of 1976, but that after May of 1976 when you are getting your full bi-weekly payment, then there is no longer any continuing cash flow problem caused by this particular change, is there?

A That depends on how I made up for the 2.6 million dollars cash gain of Montefiore Hospital between now and May 24, 1976.

I never catch up. At that point you are right. The 2.6 million dollars comes out on that basis and I go back on the regular biweekly basis.

If I'm able to take care of the 2.6 million dollars, if somebody would donate it, but you never catch up.

MR. SCHAFFER: All I wish to make clear, your Honor, is this. There is nothing in the nature of a biweekly system itself that causes the problem. It is the transition to it.

Q Is that correct?

A The taking away of 2.6 million dollars from Montefiore Hospital. That's the straw that breaks the camel's back.

Q But a biweekly system, if there was a means to transform the system to a biweekly system, there is nothing about getting paid in full at two-week intervals rather one-week intervals, is that true?

THE COURT: He says he has to borrow the money and wait for the second week to come around.

It seems to me that I don't know what we are trying to try this case about. It is perfectly clear that it happened. The question is if you are going to make up the interest cost. If you are going to make the interest cost up, they have no lawsuit. Maybe I am talking too early in the game. Let's finish with Mr. Birnbaum.

MR. SCHAFFER: Very well, your Honor.

BY MR. SCHAFFER:

Q Mr. Birnbaum, bear with me on a couple of questions, because I am not an accountant, and I have some questions that relate to accounting matters.

According to Plaintiffs' Exhibit 1 --

THE COURT: Exhibit 1 is now the typewritten copy.

Q Mr. Birnbaum, if you would turn to Montefiore Hospital on this --

A Yes.

Q Now, according to Column 1 Montefiore has currently assets of $26,122,272.

A Correct.

Q And liabilities of $17,260,714, leaving, at least on paper, a difference of $8,861,558.

A Correct.

Q Why isn't that almost $9 million available to Montefiore to make up for the loss of cash flow?

A Because of the $26 million in current assets, approximately half of that is money due me from either Medicare, Blue Cross or Medicaid.

It is a receivable. It is not cash.

Q In other words, the reason why you cannot make up the loss of cash flow --

THE COURT: He has only knocked it down to six million-three, right?

THE WITNESS: Your Honor, I said --

THE COURT: You have $8,861,558 in current assets over current liabilities, right?

THE WITNESS: Yes.

THE COURT: And you are saying that you do not

$8 million available to you because included in there are two million two and a half dollars of receivables?

THE WITNESS: I said $12 million.

BY MR. SCHAFFER:

Q Therefore, what you are telling me is that the inability to dip into your own cash reserve to make up the cash flow is the result of the fact that you have money owing to you from other sources other than Medicare, and that these other sources have not paid you, is that true?

A As a matter of fact no cash reserve to dip into. A significant amount of the $13 million owed to me is owed to me by the Medicare program because of the fact at Montefiore Hospital the number of Medicare patients keep increasing at a faster rate than I can go back to the intermediary to get additional money to increase my PIP because of the fact we have to wait a quarter to see how many bills get processed, and what-have-you. A considerable sum of that is due from the Medicare program.

Q About how much?

A I could not give you an answer offhand now. I would imagine this would range somewhere between probably three and four million dollars. I know, for example, a figure that I have at hand is that Medicare owes Montefiore

Hospital for care rendered in our outpatient and emergency room some $1,600,000 for the years 1972, 1973 and 1974, but I have not been successful in getting it from intermediary.

Q And the remaining $10 million?

A That was outpatient. I would offhand say somewhere in the neighborhood of three to four million dollars due from the Medicare program.

Q That would leave $10 million due from other third-parties.

A Correct.

Q If that money had been paid or were available, you would then be able to make up the loss of cash flow without having to borrow, is that correct?

A Possibly.

THE COURT: That means you are going to put the burden on the other payees, payors to carry your deficit. He says if you paid them what you owed him he could take care of it.

MR. SCHAFFER: I want to point out that the situation is not due solely or largely due to Medicare delays.

THE COURT: He said to forget everybody else and he could carry the load.

THE WITNEFSS: You are the straw that breaks the camel 's back.

BY MR. SCHAFFER:

Q But there has been a lot of other straws put on your back before.

A Yes.

Q If, in fact, you do have to go out and borrow to make up for a loss of cash flow, Medicare will reimburse you according to your percentage formula for the interest on that loan.

A To the extent that I exceed no other ceilings in the Medicare program of definitions of reasonable cost, the answer would be yes.

Q So that the Medicare reimbursement for interest on that loan would be the same as Medicare reimbursement for past notes.

A Correct.

Q No difference in the reimbursement because the past loans were not caused by Medicare payments, but by other people and the need to take out a loan this time may be caused by Medicare that is irrelevant.

A Yes, sir. Again, to the extent that I exceed no other ceilings in the Medicare program.

I happened to point out an item in dispute

between the Government and Medicare, and the Montefiore Hospital because, in fact, I' being penalized to the tune of about close to $2 million a year because of an issue in controversy.

Q But not in this case.

A But not in this case.

Q How often are salaries and wages and payroll items in general paid by Montefiore Hospital?

A Montefiore Hospital pays each employee biweekly, but a payroll each week, but biweekly.

For administrative convenience we pay half the hospital one week and half the hospital another week, but a biweekly for all.

Q Approximately what is the lag in payments to vendors?

A At this point and time I would say it is close to 90 days. We usually like to be around 50 or 60. Probably at this point, because of other problems with the City of New York, it is 90 days. And with our other controversy with Medicare which is $2 million.

Q Does carrying a lag of approximately 60 days endanger your relationship with vendors?

Do vendors threaten to cut off selling to you?

A Again we are talking of averates. Food

vendors are paid weekly. The Federal Government which used to get the taxes on a weekly basis, they get it later there. That has been a problem with hospitals having to do with vendors as their cruch and interest rates went crazy two years ago. The push for hospitals to pay quicker and refusal to pay except on C.O.D. notice increased greatly.

The medical practice problem where hospitals paid formerly $100 or $200,000 a year on premiums, they have gone up 3, 4, 500 per cent. In some cases a thousand per cent. Sometimes they have had to pay them off. Again we are talking averages and the supplies kept on hand, the inventories increased.

Q Keeping in mind we are talking about averages, with the 50 to 60 to 90-day lag in payments to vendors the hospitals are still able to operate.

(Continued on next page.)

A Some less better than others. I think you will hear that later on.

Q What is the greatest payment lag that Monte Fiore has ever experienced with vendors?

A During my time?

Q Yes.

A I would say it was probably about 120 days. That was about three and a half years ago.

Q Is it your testimony that in order to make up the loss of cash flow Monte Fiore would have to borrow 100 per cent of that cost, and no other source?

A I don't think I would put my vendors off any further. I think the choice would be borrowing or cutting back on needed services.

At this point I think we would feel that the services that are needed in our community and the services that we render to the State and City and nationwide and internationally, that we would probably rather take the risk than cut back on the needed services. We do 550 open hearts a year--yes, we would borrow the money rather than cut back on these needed services.

Q You have testified that in the past you have been able to put into effect a 120 day lag with respect to the vendors, is that correct?

MR. IMBERMAN: Isn't that repetitious?

THE COURT: True. You are getting argumentative really.

MR. SCHAFFER: No further questions.

REDIRECT EXAMINATION

BY MR. IMBERMAN:

Q Mr. Birnbaum, Mr. Schaffer asked you about your making prior loans, and the interest cost being spread out. These prior loans were for general hospital purposes, am I right?

A Correct.

Q And the cost was divided between Blue Cross, Medicaid, Medicare and your profit?

A Right.

Q But if you had to borrow money because of the PIP change that would be specifically because of the change in the regulation, am I right?

A Correct.

Q But Medicare would only pay its 45 per cent of the interest.

A Correct.

Q And these people would pay the 55 per cent?

A Absolutely correct.

Q You testified about your lag in payments. You

said now you are up to 90 days and you hope to be around 50.

Why do you have a lag of 90 days now?

A Part of the problem has to do with--

Q No money?

A Yes. Essentially the issue is that there is less money coming in than is going out.

Q Would the situation be better or worse with the change in the PIP program?

A The situation will be $2.6 million worse. Considerably worse.

MR. IMBERMAN: No further questions.

MR. SCHAFFER: One further question, your Honor.

THE COURT: Yes.

RECROSS EXAMINATION

BY MR. SCHAFFER:

Q The money that is lost in cash flow as the result of the modified program, if you have to go out and borrow that money to meet payrolls and to pay vendors, you will be paying employees and paying vendors for goods delivered and services performed on all patients, both Medicare and non-Medicare, is that correct?

A Correct.

MR. SCHAFFER: Thank you.

THE COURT: Before you go, Mr. Birnbaum, what is the proportion of the cost for personnel, salaries and supplies, vendors?

In other words, they broke this down and you say you pay employees biweekly, and your vendors 90 days. If you take your total cost, what percentage is the employee paid?

THE WITNESS: In our hospital I believe somewhat higher than Mr. Ingram--he gave 62 per cent for all salary and another 10 per cent for fringe benefits. Looking at the total package, I would say probably 75 per cent.

THE COURT: The employees' cost is 75 per cent of total cost?

THE WITNESS: Yes, your Honor.

THE COURT: And the vendor cost?

THE WITNESS: 25 per cent. And the depreciation being an element of cost which is obviously a non-cash element, of course. It is a minor one.

THE COURT: And you say employee category and vendor category covered the total operation of the hospital? In other words, you can put your total cost into two categories?

THE WITNESS: Essentially, your Honor--

MR. SCHAFFER: If your Honor please, are the

fringe benefits also paid biweekly?

THE WITNESS: In some cases, they are paid weekly, and in some cases they are paid biweekly or montnly. For example, Social Security is three days after the hospital--the hospital expense of Social Security is paid three days after. That is what I include in the fringe benefits.

BY MR. SCHAFFER:

Q What are the other fringe benefits?

A It would be payments to the union, welfare fund, payments on the hospital pension plan, payments to other pension plans, and they might be biweekly or monthly.

MR. SCHAFFER: Thank you.

THE COURT: How long will your next witness take on direct examination? I have a problem.

Before you showed up last week, I had a conference scheduled for 2:00 and in between scheduling that conference and your coming in, we decided to swear in a new Magistrate. I have to be there.

I think we are going to have to put this off until 2:30 this afternoon. We will sit until quarter to five. If we do not finish today, we will go on Monday morning.

MR. SCHAFFER: The Government has a witness from Baltimore. We would appreciate putting on our witness

bjmjb 6

during the hearing today.

MR. IMBERMAN: I have no objection.

THE COURT: We will see you at 2:30 then.

(Luncheon recess.)

AFTERNOON SESSION

THE COURT: The next witness.

MR. IMBERMAN: If your Honor please, before I call the next witness, I would like to offer what I think would be a joint exhibit with the Government, certain documents which constitute the various intermediary letters, the proposed regulations and the actual regulations as promulgated so that your Honor can have these actually as part of the record.

I know they are found in the code, but sometimes it is difficult to get hold of them.

THE COURT: I will take it. Do you have an objection, Mr. Schaffer?

MR. SCHAFFER: No, your Honor.

(Plaintiffs' Exhibit 2 received in evidence.)

MR. IMBERMAN: Perhaps I ought to read what they are, Judge.

Exhibit 2 consists of the following documents: Part A intermediary letter number 73-24, dated June, 1973. We have reproduced that as it appears in the Medicare and Medicaid Guide at page 9277. The CCH Medicare-Medicaid Guide.

The next document is Part A intermediary letter

number 73-37, dated September, 1973. We have reproduced that as it appears in the Medicare-Medicaid Guide at page 26,752.

The next is the notice of proposed regulation, and the regulation itself. The notice is dated November 20, 1973. This appears in the Federal Register, Volume 39, at page 2011.

The next document is the notice with respect to the Periodic Interim Payments which appears in Federal Register, Volume 40 at page 29,815. The effective date is August 15, 1975.

The next is the notice with regard to Periodic Interim Payments which appears in the Federal Register, Volume 40, dated September 2, 1975. That notice is dated August 27, 1975. The page of the Federal Register was published on Tuesday, September 2nd.

The last item is intermediary letter number 75-58, dated October of 1975. The subject is Periodic Interim Payments Conversion From Weekly to Biweekly Cycle. That is the document attached to the complaint, your Honor.

THE COURT: All one exhibit?

MR. IMBERMAN: Yes.

THE COURT: That has been received in evidence.

P H I L I P C. A B R A M S, called as a witness after having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. IMBERMAN:

Q Mr. Abrams, where do you live?

A 30 East 72nd Street, Manhattan.

Q What is your occupation?

A I am executive director of the Jewish Hospital and Medical Center of Brooklyn.

Q How long have you been in that position?

A Approximately four and a half years.

Q Briefly for how many years have you been involved in hospital administration in the New York area?

A Since 1948.

Q Are you a member of the American College of Hospital Administrators?

A I am.

Q How large a hospital is the Jewish Hospital of Brooklyn?

A The Jewish Hospital has 636 beds and 99 bassinettes.

Q Where is it located?

A It is located at the corner of Clauson Avenue

Avenue and Prospect Place in Brooklyn.

Q What area of Brooklyn does the hospital serve?

A The hospital serves an area consisting of Bedford Stuyvesant, the western part of Faren Heights and part of Ft. Greene.

Q Have you been sitting in the courtroom during the testimony this morning?

A I have.

Q Is your hospital receiving Medicare payments under the original PIP program?

A It is, yes.

Q What is the weekly payment that your hospital receives?

A We receive approximately $200,000 per week.

Q Mr. Abrams, I am going to show you Exhibit 1 which has some information on it including the Jewish Hospital and Medical Center.

Column 4 on that exhibit indicates the weekly PIP payment. Is that accurate for your hospital?

A I said we were receiving approximately $200,000, I believe.

THE COURT: I do not think it is going to make that much difference. This is accurate I gather as of the date it was made up.

The difference is not going to have any impact on the decision in this case.

MR. IMBERMAN: All right.

BY MR. IMBERMAN:

Q Mr. Abrams, to what extent does your hospital rely on this weekly payment?

A We rely, of course, a great deal on the advanced payment because of the need for the cash flow that we have.

Q What is the hospital's net working capital position?

THE COURT: He wish he had one according to this record.

A Well, the cash flow statement by the most recent nature indicates we are approximately minus $2 million.

Q This Exhibit 1 indicates you have a deficit of $4,462,000.

A Accumulative as of the date of this.

Q Would it be approximately the same as today?

A No. It is greater today.

Q Closer to $5 million?

A I would say closer to five.

Q If the new PIP program goes into effect, what would happen? What would be the financial effect in your hospital?

A I think somebody before mentioned a potential straw that would break the camel's back. The reduction of even one week's check at this particular time would have very adverse effects on the operation of the hospital.

Q Tell me specifically what you mean by that.

A Well, we are working now on borrowed funds from banks against future payments, but I think that we have reached the extent of our capability of borrowing from the banks on the basis of our financial position and current financial status.

Q In your borrowing from the banks have you furnished the banks with financial information about the hospital?

A We have furnished the banks at each borrowing. It is a roll-over type of borrowing based primarily on the advances that we are getting.

Q From whom?

A From the third-party payers.

Q You mean you are borrowing against that?

A Yes.

THE COURT: You never catch up then, do you?

THE WITNESS: No, sir.

THE COURT: How do you stay alive?

THE WITNESS: We always live in hospitals. We

are serving a community which is an underprivileged community.

We have tried to maintain that as best we can, the quality of medical care that the Center has been giving for almost 75 years. One always hopes for a miracle to be able to continue this kind of service. The options are obvious.

BY MR. IMBERMAN:

Q If you would have to curtail any of these services, is there another hospital that would furnish these services in the Bedford Stuyvesant area?

A No other hospital that would furnish the services we have at this particular time, no.

THE COURT: Let me understand something. This Exhibit 1 as of December 31, 1974 shows that you have a net operating deficit of $4.5 million, right?

MR. IMBERMAN: Working capital, your Honor.

THE COURT: Didn't I say net current?

MR. IMBERMAN: No. You said "operating deficit."

THE COURT: I meant the net. The current.

You say it is now over $5 million.

THE WITNESS: I would say it is closer to $5 million, yes, sir.

THE COURT: And even if the Government paid you

on time or continued to pay you under the present program, that deficit would continue to increase, wouldn't it?

THE WITNESS: It would unless certain steps would have to be taken, yes.

THE COURT: You would have to take the steps whether you stayed on PIP or not.

THE WITNESS: We would have to take the steps. They might be minimized in the sense of the reduction of care to patients.

We have a large ambulatory care and a large emergency room for that particular neighborhood. There is no other nighttime private facility available in that area.

Our clinics see approximately over 100,000 visits a year.

THE COURT: How many of those would you say would be Medicare patients?

THE WITNESS: Of that, 5 or 10 per cent is Medicare. In the clinic, that is the out-patient department. In the emergency room we have pretty close to 50,000 visits a year. It is almost impossible to tell how many of those are Medicare because that neighborhood is not necessarily an older neighborhood from an emergency room standpoint.

BY MR. IMBERMAN:

Q Mr. Abrams, if the new PIP regulations go into effect according to the figures, you would lose $1,600,000 between now and May of 1976, right?

A It probably would be more because of the increased costs that would be going into the PIP adjustment.

Q What would you do at the Jewish Hospital Medical Center to make up for that loss of the cash flow?

A Well, it is obvious that we would have to cut back either in services, try to make some kind of an arrangement with the unions, 10 per cent of our expenses roughly are in fringe benefits, most of it.

We have a hospital of 2100 employees, and all but 120 are in a union of one form or another, including our salaried physician staff. Each one has their own fringe benefit package. We would then have to try to make an accommodation to postpone possibly until such time as the cash position line improves.

Incidentally, I might add that we are running over 92 and 93 per cent in the adult population, so that the ability to add patient days for income is fairly limited.

Q Do you have any assurance that you could work out such an arrangement with the unions and their funds?

A No.

Q Is there any possibility of your borrowing $600,000?

A The last information we have is that we are pretty much at the limit of the borrowing on what the financial statement is today.

Q Do the banks take into consideration that you have this constant flow of money from Blue Cross, Medicare, Medicaid?

A I'm sure that's the only reason they are taking it, on the basis of this information.

Q What percentage of your operating expenses at the Jewish Medical Center are represented by labor and fringe benefits?

A We are close to 80 per cent. I would say 78.

Q How often do you pay your people?

A Our people are paid on a biweekly basis. Every two weeks. It is staggered of course.

Q Do you have money on deposit from Blue Cross?

A Yes, we do have.

Q How much?

A The difference between our billings and our advances of Blue Cross--we have a difference in Blue Cross of about $150,000 payable between our billings and the advances.

Q So you have on deposit about $150,000 at all times.

What about Medicaid, do you get money in advance from them?

A Yes.

Q How much?

A $2.5 million advance from Medicaid, and we are billing 3.3 million.

Q A year?

A As of October 30th. I'm sorry. This is the figure as of October 30th.

THE COURT: So they owe you a sizable sum?

THE WITNESS: Yes, they do, sir.

Q But, of course, they have a deposit of $2.5 million in advance.

THE COURT: They are in the hole $800,000 for which they have to borrow the money.

I have deep sympathy for this man.

Q If you could not borrow the money and you could not make arrangements with your unions and the pension funds that you deal with, could you delay paying the vendors further than you are now?

A I don't think we would delay paying the major vendors, including Con Edison, Brooklyn Union Gas, New

York Telephone Company, food vendors, the oil company. There are some vendors who will wait and some vendors who just can't wait.

Q What are you going to do?

A Well, there are several options. One is to reduce service. One is to reduce the number of people that are being seen in the clinics. In other words, strengthen the size of the cash amount. Right now we have no limitation as to who is seen in the clinic. We can ask our staff to take the equivalent of Big Mac bonds, but basically we would then have to cut back some of our major programs in toto.

In other words, eliminate a complete program.

Q Does Medicare make a final adjustment with you after the weekly payments are received?

A Well, they make a final adjustment as described by the previous witnesses on the same basis of after an annual audit and adjustment, yes.

Q How far behind are they? For what year did you get a final adjustment?

A To the best of my knowledge, we have just received something for 1973.

THE COURT: Mr. Ingram has testified that sometimes you have to pay back. I gather that in each one of

the yearly post-audit situations, in some of them the hospitals owe the Government money. You are assuming that the Government owes the hospital money in every single one.

Mr. Ingram says that that is not so.

(Continued on page 108.)

MR. IMBERMAN: Your Honor, my information is, and talking in dollar amounts and not number of institutions, that approximately 90 per cent of the cases the Government owes the hospitals money and in most situations.

THE COURT: That is not what the testimony is under oath because as far as I gather Mr. Ingram testified some owe and some don't. That statement to me is a standoff.

MR. IMBERMAN: I will bring him back, because I think that is not in accordance with his belief.

THE COURT: I am saying what he testified.

MR. IMBERMAN: Then there may be an error in the testimony.

BY MR. IMBERMAN:

Q You got a final statement for what year?

A To the best of my knowledge it was 1973.

Q For 1973?

A Right.

Q Did you owe the Government money or did they owe you money?

A They owed us money for '73, and we owed them money for '72.

Q That was a standoff.

A No. It wasn't a standoff because we got a

net payment from the Government of about a little over $400,000.

Q How long had they owned you that money for?

A Well, if you go back to '73, and if it were 1973 and $600,000 in which they deducted the $200,000, it would have been for those years.

THE COURT: In other words, he said for the first year, '72, he owed the Government $200,000.

MR. IMBERMAN: And for '73 the Government owed him $600,000.

THE COURT: I am being reaffirmed in my understanding of the case. Go ahead.

BY MR. IMBERMAN:

Q Did you get interest on your money?

A No.

THE COURT: He did not pay interest either.

MR. IMBERMAN: A net in the hospital [illegible]r.

THE COURT: That is not the issue. According to the gentleman from Montefiore, Mr. Birnbaum, the testimony is that the Government pays interest on borrowings which are not caused at all by Medicare.

MR. IMBERMAN: Your Hono r, the borrowings are for the purpose of running a hospital. You could not take care of a Medicare patient if you did not have a

hospital.

THE COURT: Medicare is paying for costs they do not incur. I would assume the other third party payers cannot shift any of that burden on to Medicare, the hospital cannot.

You may proceed.

CROSS EXAMINATION

BY MR. SCHAFFER:

Q Mr. Abrams, you testified that quite apart from the modification of the PIP program, the deficit of the Jewish Medical Center will inevitably increase, is that correct?

A I didn't say inevitably would increase. I said it would increase if we did not take steps to stop it, yes.

THE COURT: In other words, if you did nothing and still continued under the present PIP program, that four and a half million dollars on Plaintiffs' Exhibit 1 which is now $5 million willo go up next year and the year after, and we all know that we cannot help that, right?

THE WITNESS: Right.

BY MR. SCHAFFER:

Q Mr. Abrams, barring the miracle for which you so fervently pray, isn't it a fact that the Jewish Medical

Center has to cut back on services and programs eventually whether or not the PIP system is modified?

A I must agree with you that we have to cut back on some programs, yes.

Q Therefore, to the extent that you are unable to get cash from any source to make up for the anticipated loss of cash flow due to the modification of the PIP program, the cutback on services will simply come sooner than anticipated, is that correct?

A I would say the cutback on programs, yes. The programs and services, right.

The reason I make the distinction is that because there are some services not directly necessarily patient related. There are other services and programs which are or have minimal effects on patient care. There are some programs and services which are directly affecting the acutely ill patient.

Q Is it fair to say then that the loss of cash flow due to the modification of the PIP program will merely precipitate the cutback on services, and it is not the sole cause thereof?

A It would possibly be one of the straws that would not only precipitate a cutback, but possibly precipitate the demise of the institution.

THE COURT: It is going to hasten the evil day.

THE WITNESS: It might very well do that, sir.

THE COURT: All right.

BY MR. SCHAFFER:

Q In view of the rather large deficit, might it not have been advisable for the hospital to have begun starting a cutback on certain services some time ago?

MR. IMBERMAN: If your Honor please, that is argumentative. I object.

THE COURT: Sustained.

I think we want our hospitals to stay as viable as possible and as long as possible.

MR. SCHAFFER: The point is that we are not the sole cause and villain as has been described.

THE COURT: He is not arguing that with you.

BY MR. SCHAFFER:

Q What is the current delay of Jewish Medical Center with respect to vendors?

A I would say currently the average is approximately 80 days.

Q What is the greatest that delay has ever been?

A During my time I think the greatest has been 100 days.

Q When was that?

A That was about 1972.

Q What was the cause of that increase?

A The cause of that increase was due possibly to -- I think the mechanics of reimbusement formula and cost control law that came in in 1970, and what occurred before in 1970 would answer it, but I don't think the Court would be interested in that.

MR. IMBERMAN: Your Honor, I think this is totally irrelevant at this point. I object.

THE COURT: He asked Mr. Birnbaum and he gave a figure of 120 down to 90 and 90.

Go ahead.

MR. SCHAFFER: I have no further questions.

THE COURT: The only trouble with that line of questioning is that the conditions are different today in 1975 than in 1972.

I would assume, and I think it is fair to assume, that your vendors are not today giving the purchaser that much leeway on payment. Because of the unsettled financial condition, he wants his money in his pocket quicker or sooner. He is not going to give you that much time any more.

You might have been able to have gotten 120 days six years ago. You can't get 120 days any more.

Their pressures of spiraling costs are hitting them too.

MR. SCHAFFER: I understand that, your Honor. I would respectfully suggest it is something we cannot assume.

THE COURT: We can't? I am making the assumption. Okay.

MR. SCHAFFER: Very well, then, you can assume it.

THE COURT: Any more questions of Mr. Abrams?

MR. SCHAFFER: No further questions, your Honor.

MR. IMBERMAN: I have some on redirect examination.

REDIRECT EXAMINATION

BY MR. IMBERMAN:

Q Mr. Abrams, do you buy items from your vendors, or do you buy services separately for Medicare or other parts of the hospital?

A May I ask you to repeat that?

THE COURT: Do you buy hamburgers for Medicare patients and Medicaid patients?

BY MR. IMBERMAN:

Q Do you buy separately?

A No.

Q Do you run the hospital separately for Medicare patients?

A No.

Q You run the hospital as a unit for all the patients?

A All patients are treated the same we hope.

Q The law requires that you treat Medicare patients as well as everyone else.

A The law requires that we see everyone that comes into the emergency room.

Q Mr. Abrams, in the event of the change of the regulations for the interim payments, wo uld that improve or worsen your working capital position the way the Government proposes?

A It is obvious it would worsen the working capital position such as it is today.

THE COURT: The minus figure.

RECROSS EXAMINATION

BY MR. SCHAFFER:

Q Mr. Abrams, with the Court's permission I do have one or two questions.

Mr. Abrams, in the past has your hospital had to borrow funds?

A Yes, yes.

Q Have you received Medicare reimbursement on the interest costs?

A I must assume, yes, that that is part of the reimbursement formula.

THE COURT: The question is if you borrow for purposes not initiated by Medicare patients or not caused by Medicare patients being in your hospital, does not Medicare still give you a proportion of the interest costs on the borrowing?

THE WITNESS: I think that I would have to, to the best of knowledge, answer yes.

BY MR. SCHAFFER:

Q Under the present circumstances if you are required to borrow in order to make up a loss of cash flow due to the modification of the PIP program, that money will be to pay for vendors and payrolls, am I correct in assuming on the basis of your answer to Mr. Imberman's question, that there are no separate facilities that these vendors and employees are being paid for services and goods that were rendered to all patients, non-Medicare as well as Medicare?

A I would like to correct your statement.

You say assuming we could borrow -- could we borrow?

THE COURT: Let's assume you could.

MR. IMBERMAN: I object to that question, your Honor. It is hypothetical.

THE COURT: It is hypothetical but one the witness can answer.

MR. SCHAFFER: The witness has testified that he cannot borrow, but there is no reason why we cannot pursue the question.

THE COURT: I have overruled the objection.

Will you repeat the question?

BY MR. SCHAFFER:

Q The question is if you can borrow money in order to offset the loss of cash flow and to pay your vendors and employees, is it not true, and the fact that you do not have separate facilities for Medicare and non-Medicare patients, that the wages and that the bills that you would be paying would be for services and goods surrendered to non-Medicare patients?

THE COURT: The trouble with that question is that you are holding back the money causing him to borrow.

MR. SHAFFER: That is correct, your Honor, but as we may argue later or on Monday, the crucial determination in deciding something is a Medicare cost is whether it is a cost of service rendered to only Medicare patients

or to all patients.

THE COURT: If you are taking the hypothetical which means they are even today -- and I think Mr. Abrams is a poor witness, not personally, but his hospital is a poor witness.

Mr. Birnbaum's was a better one. That is that he can live today with PIP the way it is. He does not have to borrow because of that. His cash flow is all right as far as PIP is concerned.

He says that, but when you make him, by May of 1967, have to borrow $2 million because of the delay you are causing, he then is in trouble. You have caused it even though that mo ney is going to be used for the payment of vendors and employees.

You have caused him to go out into the money market and borrow.

MR. SCHAFFER: Your Honor, if I may, let me try to clarify one point.

THE COURT: We do not need to keep Mr. Abrams for this. His answer is obvious. If he is in Mr. Birnbaum's situation, his answer is clear.

It has to be the same answer as Mr. Birnbaum's. He is in an unfortunate position. It makes no difference what you do to him. He still sees the deficit mounting,

and so he is not strong for the plaintiffs' point of view as Montefiore is. You make it worse for him. He has one more thing to worry about. That is in essence what he is saying. I think it is true, isn't it?

MR. SCHAFFER: Yes, your Honor, but if I may clarify one thing.

The issue of the necessity of borrowing, and the extent to which Medicare will reimburse such borrowing, comes up in one context in this case.

The first is on the issue of whether plaintiffs have shown sufficient injury to satisfy the test for a preliminary injunction.

In that context the Government contends that they will be, the hospitals will be reimbursed on the interest costs of borrowing only to the extent of their reimbursement formula. However, that does not establish the necessary injury since it has already been stated by the witnesses that the remaining interest costs will simply be passed on to other third-parties or private patients, but nevertheless it is a cost that can be passed on. They have admitted that.

THE COURT: Why should they pass it on if you caused it? Why couldn't you pay for what you caused?

That is what the case is all about. If you

are willing to tell me that you are going to pay the interest costs, I don't think the plaintiffs have a case.

MR. SCHAFFER: Let me finish this point, and I think I will answer your question.

I am just speaking for the moment to the issue of irreparable injury for the purpose of the preliminary injunction. Since the injury must be to the members of the plaintiff class, the fact that Medicare will only reimburse a certain percentage of their interest costs by itself does not show injury to the hospitals since as their witnesses have already testified that to the extent that Medicare does not pay, that is a cost that is passed on to other parties, or private patients.

THE COURT: He may not be able to pass it on because Blue Cross and Medicaid are cost based reimbursements and they are not going to reimburse or at least I assume they would not reimburse for an interest cost which you have caused.

They are only going to reimburse for the care of their patients. They are then minus at that point, and that is what they claim is their irreparable injury, and $24 million, if you want that instead of $28 million or $20 million, if you want that. It sounds irreparable to me.

MR. SCHAFFER: That we believe is the error in plaintiffs' position.

They have also claimed that the modification of the PIP system would violate that section of the Medicare Act, and the Medicare regulations which forbids the transfer of the cost of providing services to Medicare patients from such patients to non-Medicare patients. You can see this question of whether interest is going to be paid back in full or only in part relates to both the irreparable injury question, and also whether the modification of the system violates the statute.

Now, the crucial point about the Medicare system, and about the reimbursement of interest costs in particular is that, as the witnesses have already established, such reimbursement takes place regardless of the cause of the need for borrowing. So long as there is a need for borrowing. Medicare reimburses its percentage cost to Medicate. Under the statute and by the terms of the statute and the regulation, the question is is this a cost of delivering services only to Medicare patients, or is it a cost of delivering services to all patients.

When a hospital goes out and borrows money, no matter what the precipitating events of that borrowing is, it is as Mr. Birnbaum testified, a situation of

incurring a cost, the interest cost to provide services to all patients. That is the critical point.

THE COURT: But you now have been put on the spot by your attempt to spread out, or whatever the word is, your payments. You have put a specific burden on their back. It is fungible.

You can point to it and say, "There it is. You give it." They can figure out to the penny how much you have cost them. You are not paying back to them the whole interest cost on that.

MR. SCHAFFER: Your Honor, if there is an unfairness in that, and that constitutes an unfair payment by the Medicare system, then conversely all the past times --

THE COURT: You do not get credit for that in this lawsuit.

MR. SCHAFFER: What I am trying to point out is not merely the issue of fairness, but the words in the statute and regulations themselves. The regulations do not say that you cannot impose costs upon hospitals due to a charge in payment system. The regulations say that the cost of providing services to Medicare patients may not be shifted to non-Medicare patients. As the previous witnesses have testified, and our witness will testify, that that system of reimbursing interest applies

regardless of the precipitating events of the borrowing. That is simply not a relevant factor in determining whether we have violated the statute.

THE COURT: I think it is a relevant statute. I should tell everyone we do not usually run trials like this, but we have no jury here.

I am involved in a complicated issue, and everybody wants a quick decision.

Call your next witness.

MR. IMBERMAN: Mr. Hellman.

- -

L E O H E L L M A N , called as a witness, being first duly sworn, testified as follows;

DIRECT EXAMINATION

BY MR. IMBERMAN:

Q Mr. Hellman, what is your address?

A 255-12 61st Avenue, Little Neck.

Q Where are you employed?

A Peninsula Hospital Center.

Q What is your position there?

A Director of fiscal services.

Q Where is the hospital located?

A It is on 51st Street and Beach Channel Drive, Far Rockaway.

Q What area does Peninsula Hospital Center service?

A It services a small section over the Marine Parkway Bridge known as Marine Basement through the entire Rockaway Peninsula, as well as the five-town area, the other side of the border in Nassau County.

Q How large is your hospital?

A 270 beds.

Q How long have you been involved in hospital fiscal administration?

A Since 1959.

Q You have been in the courtroom during the testimony this morning, is that correct?

A Yes, I have.

Q You are familiar with the PIP system which Medicare operates under now, is that correct?

A Yes, sir.

Q Is Peninsula Hospital Center on the PIP system?

A Yes, it is.

Q According to Exhibit 1 your weekly PIP payment is $145,500.

A It has been raised to $147,500 in the past month.

Q All right. What sort of population do you

have at the Peninsula Hospital Center?

A 60 per cent of our patient days are Medicare patient days. The hospital is in the midst of a large density of nursing homes and health related facilities, most of which have senior citizens as their patients.

Q You get the inflow from those?

A That's correct. When the senior citizens require acute care, they generally come to our institution.

Q Mr. Hellman, to what extent does Peninsula rely on its weekly payment from Medicare?

A It is the prime source for our payroll.

Q How often do you pay your people?

A We pay biweekly.

Q If the new PIP system were to go into effect, what would be the effect on the Peninsula Hospital Center?

A An absolute disaster.

Q Why? Would you explain to the Judge why?

A We would lose approximately $450,000 to $500,000 of cash flow which, in effect, already on the top of a bad situation would make things just about catastrophic.

We are unable to borrow money.

Q Why?

A We, at the present moment, have a working capital loan which we received approximately two months

ago of $1,200,000. One of the provisions of the loan agreement is that it is the limit of borrowing which we are permitted to have.

We would probably have to extend our vendor payments which presently is at 110 days to something well over six or seven months which in turn would probably mean a cutoff of supplies. If that did not happen, if they were kind enough to give it to us, it would mean a substantial increase in price for all our goods.

Q Why an increase in price?

A Well, the vendor has to borrow the money or support us. He is a financing agent. He has to pay for money. Therefore, knowing that we need our goods badly to take care of our community, they would jack up the prices as high as they can go knowing full well we have no place else to go.

In addition, we would probably have to hold back payments from our own union from the employees which I dare say in past years has caused a lot of rumbling and could precipitate a walkout. We would probably have to hold back payment for the Federal Government for withholding taxes. We would try anything we have to do to maintain services to our senior citizens in our area. We are the only hospital there.

Q What did you do with the $1,200,000 that you borrowed?

A We paid off vendors. At the time we were six to eight months with many vendors, and we brought them down to 100 and 110 days. That's where we are now.

Q Do you have an agreement with the bank how you are going to repay that?

A Yes. We have to repay them on the level basis over a period of five years. They originally wanted one year. We told them that was unsound. And through the good faith and community support of the bank, Chase Manhattan Bank, the course of our lending, they consented to a five-year repayment schedule which is highly unusual, I might add.

Q Mr. Hellman, Exhibit 1 indicates that as of December 31, 1974 you had a plus on your working capital situation of $1,950,000.

A I would like to explain that, because it is a misleading number.

Q Tell the Judge.

A Of the $1,900,000, $1,600,000 is an investment in a long-term care facility which is part of the total Peninsula Hospital Center.

That investment of $1,600,000 in that building

is not liquid. It is sitting in the bricks and mortar of that building.

The balance of the $300,000 of that working capital has been exhausted during this entire year because of deficits. So, in effect, the present norm at the hospital has a net worth on the minus side.

THE COURT: This is current liability.

BY MR. IMBERMAN:

Q Why is the investment in bricks and mortar not a current asset?

A I would say it is an accounting question that the CPA's at the time decided to treat that way.

I wasn't there at the time, but that's what they did. I think they consider it a current investment. In another institution -- in effect, it is a separate corporation.

Q In any event --

THE COURT: You better take it up with your accountants again.

Q In other words, you are telling the Court that, in fact, you have a negative working capital position.

A Correct.

Q And you are the fiscal officer of the hospital?

A Correct, a negative net worth at this moment.

Q Do you have money on deposit from Blue Cross?

A Yes, we do.

Q How much do you have?

A Approximately $300,000.

Q Do you use that as part of your working capital?

A Absolutely.

Q How about Medicaid? Do you have money from them?

A Yes, we do. We have $400,000 of inpatient funds, and $150,000 of outpatient funds.

Q And you use that?

A As part of the working capital, absolutely.

Q Is there any way that the Peninsula Hospital Center, through its operation, can generate working capital?

A No, we cannot. We rely on community support to help us take care of our deficits which is not nearly enough.

Q You mean charitable donations?

A That's right. Philanthropic.

Q What was the last year that you had a final adjustment from Medicare?

A We just received a settlement for 1972 about three weeks ago. The settlement was $122,000.

Q That you received from the Government?

A Correct. That's correct.

Q Without interest?

A Without interest.

Q And you have not had a final settlement for 1973 and 1974?

A No. No.

MR. IMBERMAN: No further questions.

THE COURT: Mr. Schaffer.

CROSS EXAMINATION

BY MR. SHAFFER:

Q Mr. Hellman, you have testified that when the lag in payment to vendors gets greater, vendors raise their prices.

Does that mean they raise the price to the particular institution or across the board raising of prices as the general average lag among all institutions?

A I can't answer for the other institutions because I don't know what prices they pay. I know the following, that we could have purchased -- when the lag gets greater, we are unable to buy at a good price. I have seen the comparison myself.

Q That is when your particular lag gets greater, your particular prices go up?

A Correct.

Q Since you have reduced the lag as a result of the loan, have the prices gone down?

A Yes, they have.

Q Are you currently paying interest on that 1.2 million-dollar loan?

A Yes.

Q Are you being reimbursed by Medicare for those interest costs in part?

A In part, yes.

Q According to your Medicare formula?

A Yes.

Q In the past have you had to take out other loans?

A The hospital has taken out other loans, yes.

Q Have you been reimbursed by Medicare according to the Medicare formula on those loans?

A Yes.

MR. SCHAFFER: No further questions.

REDIRECT EXAMINATION

BY MR. IMBERMAN:

Q What percentage of the operating costs are represented by labor and fringe benefits?

A .72 per cent.

MR. IMBERMAN: That is all.

(Witness excused.)

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P E T E R B. T E R E N Z I O , called as a witness, being first duly sworn, testified as follows;

DIRECT EXAMINATION

BY MR. IMBERMAN:

Q Mr. Terenzio, where do you live?

A 87 Country Club Road, Tenafly, New Jersey.

Q Are you associated with the Roosevelt Hospital?

A Yes, I am.

Q What is your position?

A I'm an executive vice-president.

Q Do you have any connection with fiscal affairs?

A Well, the people in fiscal affairs report to me.

Q Are you familiar with the hospital's fiscal situation?

A I think so.

Q How long have you been connected with Roosevelt Hospital?

A I have been the executive vice-president since 1953.

Q What area?

A Our area is nine public health areas approxi-

mately from 42nd Street, 86th Street, Fifth Avenue and the Hudson River.

Q Generally what type of people does the hospital serve?

A A very transient, mixed population. The community, we have a very active community participation in our institution. We are very actively involved in community affairs.

We know from our community studies that there were four health problems and one of which is the aged, so that we know we have a very large returned mental patients to the community in our community. We know that we have a large alcoholism problem and narcotic and drug addiction problem in the community.

Q And the fourth problem is how you take care of your aged?

A Right.

Q What percentages of the Medicare patients are in the hospital?

A 33 per cent.

Q You have been sitting here in the course of the morning, haven't you?

A Yes.

Q Is Roosevelt Hospital receiving funds for

Medicare under the old PIP system?

A Yes, we are.

Q According to Exhibit 1 your weekly payment was about $218,000.

A It has gone up some. I think it has gone up to $226 or 222 or 229, something like that.

Q To what extent does the hospital rel y on that $220,000 a week?

A Well, we are down there Monday to pick up our check too. We rely on it very, very much.

(Continued on next page.)

Q In other words, you cannot wait until it comes in the mail?

A Right.

Q What percentage of your operating expenses are represented by labor and fringe benefits?

A 72 or 73 per cent.

Q When do you pay your people?

A Weekly.

Q So that every week you rely on the Medicare check to pay your people?

A Yes.

THE COURT: Not always. He must get money from some other sources.

Q What is your weekly payroll?

A $700,000.

Q Mr. Terenzio, according to Exhibit 1, Roosevelt Hospital had a negative working capital position as of December 31, 1974 of $2,200,000.

A Yes.

Q Is the situation about the same today?

A It is worse.

Q It is worse?

A Yes. Part of that was financed by bank loans. When the bank loans--when we went for our 5 million, the

bank decided that we had to put up security. Short term was out the window. Unfortunately for us from a reimbursement point of view the only security that the bank accepted was a brand new research building. We put a $5 million mortgage on a research building.

If you don't know research is not a reimbursable item, so the interest that I am paying comes out of the hide of the institution, and not from Medicare, Medicaid and Blue Cross. It is a lower rate, however, thank God, than the rate we were paying for short term because it is a mortgage.

Q If the new proposed PIP system goes into effect, what would happen at the Roosevelt Hospital? You would be shy about $650,000 between now and May of 1976, is that correct?

A It would have to be borne completely, as far as I'm concerned, by the vendors. We are at somewhere over 90 days, and creeping up to 120 and this would push, I'm sure, into 120 days because the outstanding receivables, $[illegible].5, outstanding payables about $4.5 million, and this would add another $600,000 to that amount.

Q Is there a possibility or probability that some vendors will not wait that long?

A We were sued by Con Ed, and had to make a nice

settlement from Con Ed's point of view, and a disastrous one from ours.

We compromised and agreed to pay current billings and work off the old debt of $800,000 at the rate of $100,000 a month tacked onto the current bill. We have to keep that up to date or they claim they will turn the lights off.

Q Are there other vendors that will not wait that long to get paid?

A Fortunately we have not had much pressure. I'm convinced that we are paying higher prices for some of the items because we are slow pay, and we get pressures and telegrams from Chicago and letters from other places in the country where people want their money, but no one has talked about Chapter XI or anything else.

Q Higher price results in higher operating costs for you, don't they?

A Yes, sir.

Q Could you borrow the $650,000?

A No, sir. At least I would have to develop--at least from the bank's point of view I would have to put up collateral. I have no collateral to put up. We tried to give them the restricted endowment, and they tell me it is no good.

Q Do you have money on deposit from Blue Cross?

A Yes. About $900,000.

Q Working capital?

A Working capital.

Q Do you have money on deposit from Medicaid?

A Yes.

Q How much?

A $2 million for in-patient and $800,000 for out-patient.

Q And you use that for working capital?

A Also being used for working capital.

Q When was the last time that you had a Medicare settlement?

A 1972.

Q What did that result in?

A We got a check. I don't think it was a particularly big one. Two or $300,000.

Q Did you get paid interest for the delay?

A No, sir.

Q You have no final settlement for 1973 or 1974?

A Not yet.

Q Is Medicare usually that far behind, two or three or four years, in settlements?

A I think all third-party payers are that far behind on final settlements.

MR. IMBERMAN: I have no further questions.

CROSS EXAMINATION

BY MR. SCHAFFER:

Q Mr. Terenzio, when the price of goods goes up because vendors are charging more due to the payment lag, do you get correspondingly high reimbursement from Medicare?

A Unfortunately I happen to be in a horrendous situation. I consider myself a class one hospital because I'm a medical school institution, but because I have less than 14 residency programs, I'm classified as a class two hospital.

As a class two hospital I'm compared to Brooklyn Jewish, Maimonides and other hospitals rather than Presbyterian and New York. There is a limitation on the formulas. They build in limitations. I'm at the top of the scale. We have had to retract what we have been doing all during 1975 and will continue to do in 1976.

Q Prior to the time that you reached the top of that limitation as your cost would go up, would Medicare reimburse at least a percentage of that cost that did go up?

A Yes, sir.

Q What about the other third-party payers besides the Medicare, are you at the top level for them as well?

A Yes, sir.

Q As your cost to vendors went up, did your reimbursement from the other third-party payers pay as it went up?

A The formula is a prospective. You are not reimbursed for your expenses today until two years from today. With that two year lag the answer would be yes, after you provide for the two year lag.

Q After we have taken into account all the third-party payers, about what percentage of your costs would be left?

That is, what percentage that is not reimbursed by third-party payers, but I take it is borne by pension funds or private individuals?

A It would depend on whether you would take into consideration my total deficit which in 1974 was $10 million, or whether you take in just the operating deficit which was $5 million, and whether you would subtract from that over the million and a half dollars that we raised for operations in philanthropy--so that my real operating deficit should have been $6,500,000. When you take a look at the fact that the operation is between 50 and $55 million, we are running about 10 to 12 per cent loss that I am not getting reimbursed for.

In other words, I'm being short-changed by the reimbursement formulas, the underfinancing, by somewhere between 10 and 12 per cent.

Q I am not sure I understand how that answers my question. Let me rephrase it.

With respect to private patients, whatever the percentage is, as your costs go up, don't your charges to your patients follow suit and also go up?

A Charges and reimbursements?

Q Charges as vendors charge you higher prices--

A Right.

Q To some extent is that passed on?

A That's passed on, as I pointed out, in the case of Medicare and in the case of Medicaid and Blue Cross because of prospectivity and the two year roll-over that I have to wait for two years for them to catch up with the higher prices.

Q With respect to the private patients, is the higher cost of goods from vendors passed on to them as well in the form of goods?

A It has to be.

MR. IMBERMAN: Your Honor, I would like for the record to explain, and for the record to have him explain what he means by "prospectivity".

THE COURT: Ask him.

Q Could you explain to the Court how the prospectivity system of reimbursement and Blue Cross operates so that you have to wait two years to get paid?

A As Mr. Birnbaum explained to you this morning, the three principal players are Blue Cross, Medicare, Medicaid. Until 1969 all three were on a cost reimbursement basis. There was a little difference because Medicare was on the RCCAC formula. The other two were on straight costs. Costs across the board.

In 1969 when the cost control legislation went into effect, the concept of paying you based on your current cost, because in those days when you were paying cost, when you are paid costs, obviously in 1969 I was being paid on 1967 costs I carried on my books because I was not on a cash basis. I was on an accrual basis which I thought Medicaid, Medicare and Blue Cross was also.

Eventually that money would come in, and I would get caught up. But in the beginning of 1969 the Medicare, Medicaid and Blue Cross went on prospective rating which meant they were not going to go back except to look at and audit your accounts, but no go back and adjust and make you whole again. They looked ahead and tried to build in some factors as to what they thought was going to happen

to the price this year, and gave you the money now.

The effect, of course, is that it works very good if you don't grow. But if you grow any and put in new services that you have not been able to get paid for or if the costs in your institution for some unknown reason go up higher than you expect, or you borrow more money than you planned to, or within the factors that they allow you, why you are going to find yourself in the hole.

That is what happens with prospectivity. When I tell you that the whole health care system is being under-financed, I mean it.

THE COURT: You mean you never catch up?

THE WITNESS: No, sir, not under the system as it exists now. You never catch up with the prospective system. They don't go back. Medicaid does. They will go back and eventually--and you heard the people say to take a look at the figures and they settled '72--and this is what they owe you. We don't have that in Medicaid and Blue Cross. We can bring actions and go before review committees and try to get them to change their mind and give us more dollars. We have done it with larger union settlements and they have made adjustments for that. But we never catch up.

BY MR. SCHAFFER:

Q If you have interest costs because you borrow

money this year under the prospective system, do you have to wait two years before you are reimbursed for that from Blue Cross?

A Yes, sir.

MR. SCHAFFER: No further questions.

THE COURT: I do not know how it helps your lawsuit because he tells me the Government treats them better than Medicaid.

Is that the State or the Federal?

MR. IMBERMAN: No. It goes through the State but comes from the Federal Government. If your Honor please, at this time I would like to amend paragraph 19 of our complaint which alleges that the members of the class will be deprived in excess of $12 million of cash flow on December 1, 1975, and in excess of $35 million of cash flow by May 31, 1976 to reflect the figures which represent the loss to the class as now shown on the third page of Exhibit 1. That is where the weekly figure is shown at paragraph 19, and the bottom line on the third page of Exhibit 1 shows the figures which I would ask your Honor to consider as the amendment.

That is, the weekly payment will now be $9,457,100. The payment or the loss by May 31, 1976 would be $28,371,000.

THE COURT: Do the plaintiffs rest?

MR. IMBERMAN: I would like to recall Mr. Ingram for that one point.

J A M E S C. I N G R A M, recalled as a witness after having been previously sworn, testified further as follows:

REDIRECT EXAMINATION

BY MR. IMBERMAN:

Q Do you understand that you are still under oath, Mr. Ingram?

A Yes.

Q Mr. Ingram, about how far behind is Medicare in making its final settlements with voluntary hospitals in the New York City area?

A Approximately two years at any one time.

Q In the dollar volume of the settlement, could you tell the Court approximately what percentage results in payments to the hospitals, and what percentage results in payments to the Government, if any?

A At least 90 per cent are payments to hospitals, about 10 per cent or less.

THE COURT: You mean 90 per cent of the hospitals get paid additional money?

THE WITNESS: Your Honor, it is 90 per cent of the money.

THE COURT: 90 per cent of the money going into two hospitals--that does not mean anything to me.

THE WITNESS: I do not honestly know the number of hospitals, your Honor.

THE COURT: That is the important factor. If two hospitals pick up the 90 per cent, there is no class. You have two hospitals.

BY MR. IMBERMAN:

Q Mr. Ingram, from your personal knowledge would 90 per cent of the dollars go into two hospitals?

A No, it would not.

THE COURT: Well, he can figure out that number and let me know on Monday.

MR. IMBERMAN: I will try to get you the precise figures, your Honor.

Q But of the dollar value of the settlements you say that 90 per cent goes to the hospital from the Government?

A Yes.

Q And about 10 per cent goes the other way, with regard to the large voluntary hospitals, hospitals in the City of New York, and can you tell us in which category they fall?

A They fall into the 90 per cent category. My recollection is from the standpoint of hospitals the figures go well over 90 per cent. That is the number of hospitals involved.

From a dollar standpoint, it is about 90 and 10.

Q For the number of hospitals it is over 90 per cent?

A That's right, and this is the result of the policy deliberately.

Q By whom?

A Blue Cross, the intermediary carrier, deliberately holds that money because of the pressure of the Federal Government to not overpay hospitals so we would compute conservatively the current per diem cost which is not an easy calculation to make. And we would, having computed it conservatively, then hold back 2 per cent. This is a well known policy and some hospitals, if they gave us a letter stating that they would repay the money within 30 days, would have this 2 per cent included in their current PIP payment, but very few did that.

Montefiore was one that did. And so when I talk about the ratio of payments going out of the hospital on final settlement, I can tell you of my own knowledge that by far the greatest bulk receive these, and they did

it as a result of a deliberately considered policy.

Q At the request of the Government you hold back about 2 per cent?

A Not at the request, but as the result of pressure from the Federal Government and the difficulties in recouping overpayments.

MR. SCHAFFER: Your Honor, at this time I would like to object to the relevance of all this testimony.

THE COURT: I will take it.

2 per cent does not seem like an awful lot.

A hospital can expect to get paid 100 cents on the dollar for the services that they render within two or three days after the services rendered.

MR. IMBERMAN: The Government regulations require it, your Honor.

THE COURT: It is unrealistic. The regulation is that you get paid within a month.

You want to sue them on that, that's another ball game, isn't it?

MR. IMBERMAN: I don't think the regulation says that, your Honor.

THE COURT: Thank you, Mr. Ingram.

(Witness excused.)

MR. SCHAFFER: Your Honor, I would like to state

for the record that with reference to the testimony concerning Medicaid's prospective testimony and the fact that it is State governed and not Federal governed --

THE COURT: We have clarified that.

Would you like to put your witness on the stand?

MR. SCHAFFER: Yes, your Honor.

The defendant calls John Jansak.

- -

J O H N W. J A N S A K , called as a witness, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SCHAFFER:

Q Mr. Jansak, where do you live?

A 3410 Meadowdale Drie, Baltimore, Maryland.

Q What is your current occupation?

A Chief of the Provider Reimbursement Policy Branch, Division of Provider Premium Reimbursement & Accounting Policy Bureau of Health Insurance.

Q How long have you held that position?

A Two years, a little over two years.

Q Prior to holding that position did you occupy any other position in the Bureau of Health Insurance?

A Before that I was Section Chief in the same branch for several years. Before that I was -- I have

been in the Provider Reimbursement Policy Branch since 1967.

Q Could you explain for the Court the way in which the Provider Reimbursement Policy Branch relates into the hierarchy of the Medicare system?

A Well, in areas concerning Provider Reimbursement, we do studies, analytical work, preparation of memorandums, regulations in draft form, and make recommendations through our Bureau Director to the Commissioner of Social Security, and then to the Secretary of Health, Education & Welfare.

Q Could you explain more particularly with reference to the promulgation of regulations the role of your branch in that process?

A We generally prepare the recommendation.

THE COURT: Can you get down to the specifics? We want to know what he did here.

MR. SCHAFFER: I just want to make it clear for the record, your Honor, that he is in a position to speak for the way in which this particular regulation was promulgated.

THE COURT: We assume that.

BY MR. SCHAFFER:

Q Mr. Jansak, can you briefly explain the way in which the original interim reimbursement system worked when

Medicare was first enacted?

A Mr. Ingram alluded to that quite correctly. When Medicare started out in about 1966, it took into account the traditional way that the hospitals were reimbursed by third parties in this country. That is, the patient went into the hospital, admitted to the hospital, would prepare a bill, and the bill would then be processed by the hospital and sent to the third-party, and there would be a payment in return.

The Medicare program was rather a large program at the time, about one-third of the inpatient days in this country, and in the first several years, the hospitals and the intermediaries got backlogged because of unfamiliarity with the Medicare process.

Q Did there come a time in 1968 when an alternative interim payment system was offered?

A The hospitals in 1968 were complaining that the intermediaries were not processing the bills fast enough. The intermediaries in turn indicated that the hospitals were not preparing the bills fast enough. Therefore, to provide what we would call predictable cash flow to the hospitals without regard to the administrative action of the hospital or the intermediary and clerical review, we provided what is called the Periodic Interim Payments or

PIP procedure.

It was designed primarily to provide predictable cash flow because of clerical difficulties in the two sides I mentioned.

Q Can you explain briefly how the PIP system provides such predictable cash flow?

A Under PIP or the interim estimate, you try to calculate what it is costing a hospital to produce services. You try to estimate the volume of services they are producing and PIP, you sent them a check which is supposedly equal to the amount of service they render to Medicare beneficiaries at that time.

And from time to time during the year as cost increases, or the organization shifts, that amount should be adjusted so that at the end of the year you are in a relatively neutral position.

Q Under the original PIP system what was the time interval of payment? Was that mandated by the system or was that left up to agreement?

A Under the original PIP system the payment would have been weekly or biweekly. Although the theory was proscribed, the time was not proscribed at the time. Although, most hospitals moved to a one-week system as it progressed. I would say when PIP started off, it was not

very popular with the hospitals.

They preferred the traditional system. And under what I would call the old PIP system, about 800 hospitals out of 6700 hospita,s in the country ever moved to it.

(Continued on next page.)

THE COURT: Do I understand that 5,900 of the hospitals stayed under the original system, and only 800 moved to the system that would help them in a cash flow?

THE WITNESS: Yes, that would be correct. I should add one thing. The one thing is that the traditional system also had what we called the current finance procedure which was the payment to make that more attractive was in the form of--I guess I would describe it as similar to what is going on here in New York City.

That was also part of the factor.

Under the new PIP system some 500 hospitals have moved to that one.

THE COURT: What do you mean the new PIP system? I gather that you had an original system in '66, and a new system in '68.

MR. SCHAFFER: Your Honor, I can do this chronologically. I think it will become clear.

BY MR. SCHAFFER:

Q So we have in 1968 a PIP system created whereby payment would be paid weekly or biweekly, and most or nearly all the hospitals elected to receive payments weekly.

A Yes.

Q And during the time that that system, the weekly PIP system, was available, that would be from January of

1968 until January of 1973, 800 of the 6,700 hospitals in the Medicare system elected to switch to the weekly PIP system, is that correct?

A That's correct.

Q In devising that PIP system were any formal regulations promulgated, or was this done on an informal administrative basis?

A It was done on an informal administrative basis in 1968.

Q At the time it was done, was it anticipated that sometime in the future it would be codified into a regulation?

MR. IMBERMAN: If your Honor please, I object to that because this goes to part of it.

THE COURT: In 1968 it does not make much difference what happened, does it?

Q Did there come a time in January of 1973 that the Bureau of Health Insurance imposed a moratorium on new hospitals switching from the traditional reimbursement method to the PIP system?

A Yes. At that time there had been some concern that the PIP system was providing payments to hospitals out of--

MR. IMBERMAN: If your Honor please, may I

object to the witness' answer that there was some concern some place.

The question was did they codify it. He is going to give us answers which are really not proper.

I will have no way of testing this on cross examination.

THE COURT: The objection is sustained.

BY MR. SCHAFFER:

Q Just answer the question yes or no.

Did there come a time in January of 1973 that a moratorium was placed on new hospitals switching from the traditional system to the PIP system?

A Yes.

Q At the time that that moratorium was placed, did your branch and the rest of the hierarchy of the Social Security Administration and HEW involved in the procedure reimbursement policy, did they undertake a reexamination of the PIP system which was then in use?

A Yes.

MR. IMBERMAN: If your Honor please, I object to that and move the answer be stricken.

I don't know how this witness can testify to what the rest of the hierarchy was doing.

THE COURT: He was there and he is testifying

the same as Mr. Ingram testified.

They have to produce a witness, and this is the man who knows. You can cross examine.

MR. IMBERMAN: He can talk for himself I suppose.

THE COURT: No, he is the Government's witness. He is not talking for himself. He is the Government's witness. The Government is the defendant in this lawsuit.

MR. IMBERMAN: Yes, sir.

BY MR. SCHAFFER:

Q And for what purpose was this reexamination of the PIP system undertaken? That is, what were some of the concerns that your department had at that time?

A One concern was that it seemed to be a payment cycle much faster than that being received by most hospitals under the traditional cycle.

Q The weekly payments were coming--

THE COURT: You are talking so fast that I am losing it. Start fresh, Mr. Schaffer, and put your question to the witness again.

Q You have stated, I believe, Mr. Jansak, that one of the factors being considered by your department in reexamining the PIP system was the question of whether, under PIP, hospitals were getting paid substantially faster than hospitals that were still under the traditional

reimbursement method, is that correct?

A That's correct. That was one of the major concerns.

Q At that time did you have factual evidence before you, and when I say you, I am going to be referring consistently to the department, did you have factual evidence before you concerning how fast hospitals under the traditional reimbursement system were, in fact, getting paid?

A Yes, we did. There is a regular procedure of intermediary work flow and provider billing preparation study that has been in effect almost since the program began.

In 1973, for example, the average length of stay by some statistics of the American Hospital Association indicated a length of stay of 11.4 days, or something like that.

It also indicated--

Q (Interposing) Patients over 65?

A Patients over 65 who have a longer length of stay than the younger population.

They also indicated that the provider or the provider bill processing time was about 19.4 days, and that would be the time from which the patient was discharged to

the time the intermediary received the bill. Then on the national calculation, it seemed that the national bill processing time for intermediaries was 2.8 days. Then you would add to that--this would depend on when the check was received because checks are not always mailed or prepared the same day by the computers. That might take one day or seven days, or you might approximate an average of three days and the mailing another day.

And if you assume that the length of stay should be divided in half to determine the average lag, then you get a lag here in most cases under the traditional billing method of about 30 days.

THE COURT: You say a lag of 30 days. From when to when?

THE WITNESS: That would be from the time the patient was discharged until the time the payment was received.

BY MR. SCHAFFER:

Q Wouldn't that be the lag from the time of service because you divided the length of say in half?

A Yes. You are right. Because I added that fraction back in. You are correct.

THE COURT: What is your answer now?

THE WITNESS: From the date the service was

received until the date payment was made for that service.

MR. IMBERMAN: Will you repeat that answer?

THE WITNESS: The date service was rendered to the date the hospital received its reimbursement.

MR. IMBERMAN: Your Honor, is that the last day the service was rendered when the patient was discharged, or the first day?

THE COURT: He took the average. The average stay is 11 days. He took five days.

I gather everything you have been giving me all day long has been averages. There is no other way to do it, is there?

Mr. Ingram, you are the expert.

MR. SCHAFFER: May it please the Court, I would like to clarify for the Court that the point we are talking about is the conventional reimbursement.

THE COURT: Whatever you give to me has to be done on an average.

THE WITNESS: The figures have been averaged. There has been discussion here about where you begin and end--because people have been giving different figures but they are average figures.

THE COURT: Go ahead.

BY MR. SCHAFFER:

Q On the basis of your determination that the average lag in payment for those 5,900 or so hospitals still under the conventional reimbursement system, was 30 days, what effect did this have upon your thinking with respect to modification of the PIP system?

MR. IMBERMAN: I object to the form of the question, if your Honor please.

THE COURT: He has not told us yet what the PIP system did.

Q The PIP system as operating between 1968 and 1973 had an average lag of how many days?

A The lag was three and a half days under what you would call old PIP.

MR. IMBERMAN: What is still in existence here?

THE WITNESS: The system still in existence for those hospitals under PIP prior to January '73.

Q And that would be the weekly PIP system we are talking about when you say "old PIP"?

A That's right.

Q Let's return to the general question of what factors were being considered during this moratorium period concerning possible modifications of the PIP system.

You have stated that available to the department were figures showing that the average payment lag for

traditional reimbursement was 30 days, and that the average lag under the PIP was three and a half.

What did these figures suggest to the department?

A Well, this was quite obviously a startling contrast since PIP was generally designed to design a predictability of cash flow, and the normal traditional billing did not provide a predictability of cash flow.

The department then realized that there was a cash flow advantage of a substantial nature to the old PIP methodology to providers. It was concerned whether this was appropriate in view of what most hospitals around the country were able to do under the traditional billing method and if PIP was to be continued.

There was some discussion about what should be the new payment schedule, or lag that would be provided in it. The three and a half days was it at that time.

Then it was decided to be too rapid and too much of a drain on the Federal Trust funds and not consistent with the traditional billing practices in the field.

Q Let me ask if we can pinpoint a number of things. If you say that one concern is a concern of fairness, that certain hospitals were getting reimbursed too rapidly--

THE COURT: More rapidly.

A On the one hand you had the traditional billing people for in-patient services receiving payment about 30 days of a lag. PIP was providing it at about a three and a half day lag.

Q I believe you mentioned something about a concern that the three and a half day lag was not only faster comparatively but in some other sense too fast.

What did you mean by that?

A It has been alluded to that employees are on biweekly payout schedules, or even longer, depending on how many days after the biweekly period the provider actually pays the check.

Vendors are often paid 30, 60 days later. This provides a contrast for the old PIP methodology that it seemed to provide the money even before the hospital sent the money for the service.

Q In addition you have mentioned something about the drain on the Medicare Hospital Trust Fund. Can you explain what that amount was and why there was this concern?

A Well, that is the issue--that if the payment cycle was adjusted to something more closely resembling a traditional billing cycle, that that money would be available to earn interest for the Federal Government.

Q Did there come a time in September of 1973 when

the department listed its moratorium on the PIP program, and made it available once again, but this time on a bi-weekly basis?

A In September of 1973 the department announced again, through an administrative device, an intermediary letter, that providers--

THE COURT: Just a second. Can you key that in to Plaintiffs' Exhibit 2? Is this the letter of June of 1973?

THE WITNESS: No. I think it is dated September. It is the one dated September.

THE COURT: I don't have one. I have an intermediary letter dated June of 1973, and one dated July of 1973, and one dated October of 1975. Those are the only intermediary letters identified under Plaintiffs' Exhibit 2.

MR. SCHAFFER: Your Honor, the letter in Plaintiffs' Exhibit 2--what number intermediary letter is that?

MR. IMBERMAN: 73-24.

MR. SCHAFFER: Then we seem to be talking about a letter not in evidence.

THE COURT: Let's put it in evidence.

MR. SCHAFFER: I ask the Court to mark as Defendants' Exhibit A a Part A intermediary letter number

73-37, dated--I'm afraid I can't read this Xerox.

Is this the one we are talking about?

MR. IMBERMAN: I am not certain.

THE WITNESS: Yes. I can furnish you a better copy, but that should be September of '73.

BY MR. SCHAFFER:

Q That is dated September of 1973 and on the subject of Periodic Interim Payments.

MR. IMBERMAN: If your Honor please, I think that is one of the documents that I supplied to your Honor.

THE COURT: If you did, you did not give me a date.

MR. IMBERMAN: Paragraph 2062. That shows at the bottom. It is this one here, your Honor, and picks up at the bottom of the page. That is why it may have been overlooked.

THE COURT: You did not give me that.

MR. IMBERMAN: I apologize, your Honor. I must have overlooked it.

THE COURT: All right.

Q Go on.

A This intermediary letter allowed hospitals to come back, new hospitals to come back on PIP with a 21 day lag.

That is, anyone under the traditional system could convert to the new 21 day lag. It also allowed skilled nursing facilities for the first time to move to this system, and the home health agencies and certain conditions on them, but a more liberal--all providers were made available to them.

Since that time something under 600 hospitals have moved to the new system.

Q From September of 1973 until the present 600 hospitals have moved from conventional reimbursement to the biweekly PIP?

A That's right.

THE COURT: I gather the other 800 still stayed on the '68 PIP.

THE WITNESS: Yes, we decided at that time that it would be necessary to go through the notice of rule making procedure before they could be converted for the new PIP cycle.

Therefore, we published the notice of rule making.

THE COURT: Wait a minute. You answered the question. Go ahead.

Q Just to recap the figures of it, we have 600 who switched from the traditional reimbursement to PIP under

the weekly PIP program between '68 and '73, and an additional 600 that switched from '73 to the present to the biweekly PIP.

A No. I think maybe I better say that again. 800 under the old PIP and 600 under the new.

THE COURT: And what you have left out of the new is a biweekly or weekly system?

THE WITNESS: The 21 day lag system.

THE COURT: As opposed to the three and a half?

THE WITNESS: That's right.

Q That would leave then approximately 5,400 hospitals under the traditional reimbursement method?

A Something like that, yes.

Q And those hospitals are experiencing lags in the area of 30 days on the average?

A You are using national statistics and, of course, the hospital and the intermediary can cut the figures. It depends on the area you are talking about.

Q Did there come a time in January of 1974 when the department published a notice of proposed rule making in which--

THE COURT: I didn't get the day.

MR. SCHAFFER: January of 1974.

Q Let me be more specific. Did there come a

time in which the agency drew up a notice of proposed rule making dated November 20, 1973 in which it proceeded to publish in the Federal Register on January 7, 1974?

A January 7, 1974 was the notice of rule making indicating the new PIP methodology, and the conversion of the old PIP hospitals to the new PIP lag.

THE COURT: Just a second. You say the effective date of the publication was what?

THE WITNESS: The notice of rule making--

MR. SCHAFFER: January 7, 1974.

MR. IMBERMAN: No. December 28th.

MR. SCHAFFER: I'm sorry. We have the date on which it is. The date on which it was approved, and the date on which it was published. We are all talking about the same notice, your Honor, and this is the one in Volume 39 of the Federal Register, page 2011. It is part of Plaintiffs' Exhibit 2.

THE COURT: All I am asking is the date. You have it in your hands. Tell me what it shows.

MR. SCHAFFER: It shows the notice dated September and approved January 7, 1974, and published on January 16, 1974.

THE COURT: All right. December 27th is the first date.

Q Pursuant to this proposed regulation the hospitals which were then under the old PIP system, the weekly system, they would be required, would they not, to come in under the biweekly system along with the 600 hospitals already under it?

A Right. Your numbers are wrong because I don't know how many were on the new PIP system at that time, but that was the purpose, yes.

Q And this notice of proposed rule making was the first formal procedure towards the promulgation of a new regulation, is that correct?

A Yes.

Q Pursuant to that notice of proposed rule making, did the agency receive comments from various citizens and organizations?

A We received, I would say, about 70 comments from the entire United States. From all providers in the United States.

Q And by and large who were these comments from?

A I think there were--in terms of impact or the location of the hospitals or the kinds of organizations?

Q The kinds of organizations.

A Nearly always we received comments from the American Hospital Association and the other national

associations, the Federation of American Hospitals and other individual hospitals.

Q Were these comments by and large unfavorable and critical to the proposed rule making?

A Yes. They thought that the time frame, that is moving the lag from three and a half days to 21 days, was disadvantageous to those hospitals under the old system.

I think the comments really centered around that issue. I don't think we got much in the way of comments from other than those that centered around the conversion feature. That is the hospitals who are going to move to it, we did not receive too many complaints from them.

And in the other part of the hospital field.

Q Were these critical comments read and considered by the agency?

A That, of course, is our standard procedure, that they come in through the office of the secretary.

Q Nevertheless did the agency then go ahead and promulgate as a final regulation the regulation in question?

MR. IMBERMAN: Your Honor, couldn't we just have the witness testify instead of Mr. Schaffer testifying?

THE COURT: He is leading him. So what.

MR. SCHAFFER: Your Honor, I am trying to keep the chronology straight for the presentation.

MR. IMBERMAN: You have an intelligent witness.

THE COURT: There is no jury. He knows what he is talking about whether he leads him or not.

It is 20 minutes after four. Let him go ahead and lead. Go ahead.

BY MR. SCHAFFER:

Q Mr. Jansak, could you summarize at this point the factors considered by the agency and the reasons of the agency for promulgating the regulation converting the hospitals under the old PIP system to the new PIP system?

MR. IMBERMAN: Wait. I would like to make an objection.

If your Honor please, I am going to object to this now because I think it is very clear that unless the agency promulgates the reasons why it is making a change in advance and gives people an opportunity to be heard, it is improper to advance reasons after litigation starts.

THE COURT: You can do that on cross examination. The objection is overruled.

Q Let me repeat the question. Could you summarize the factors considered by the agency and the reason for its determination to go ahead with the proposed regulation?

A The department thought that, HEW thought that the PIP payout schedule of three and a half days was not

consistent with the traditional method or the time it took for traditional billing.

(Continued on page 173.)

Blue Cross across the country, I think it is fair to say, did not do anything similar, and relied on the traditional method. Medicaid across the country did not do anything similar throughout the country.

Medicare had itself been the first to offer up this kind of a system, and possibly the predictability which was the objective of the old PIP system was a very proper way of payment for, or to hospitals, but that the speed of the payment possibly even before the hospital expended the money on resources of providing the service, was too great. And, therefore, we tried to put the two systems more into parallel with each other.

THE COURT: When you make that answer, you heard the witnesses today say that Blue Cross has money on deposit in advance of payment.

THE WITNESS: I think that that is restricted mainly to Blue Cross of New York, although Mr. Ingram can speak for the Blue Cross system.

It is my impression that across the country that is not done too often, but Mr. Ingram can speak to that.

THE COURT: He has.

BY MR. SCHAFFER:

Q I take it then it was basically the feeling

that the regulation as promulgated would preserve the predictability feature of the original PIP system, but it was desired to slow down the payments of increase the payment lag for reasons of uniformity.

A That's right.

Q By slowing down the payment time, would this also result in greater interest accruing in the Medicare Hospital Trust Fund?

A Yes, there would be of course an interest accrued to the Federal Trust Fund for those moneys that were in the Federal Bank at that time.

Q Was this a fact or considered by the agency and adopting the regulation?

A Yes, it was.

Q Mr. Jansak, under the Medicare Act and the Medicare regulations is a provider of services entitled to reimbursement for interest expenses so long as they are necessary and proper?

A That is what the regulations provide, yes.

Q Is such reimbursement available regardless of the particular reason or events which precipitated the need to borrow those funds?

A If it is deemed necessary and proper to produce patient care or activities, then it is an allowable cost

subject to reimbursement by Medicare.

Q Where the reason for the borrowing is a real cash flow problem caused by interest having nothing to do with the Medicare payment system, is that an allowable cost?

A Yes.

MR. IMBERMAN: If your Honor please, I am going to object to the question. In addition to the fact that it is leading, I think it is improper because there is no basis here for it.

THE COURT: Your witness so testified. Go ahead.

The objection is overruled.

A My answer was yes.

Q In the situation that might occur that the plaintiffs anticipate where the borrowing was occasioned by a cash flow problem precipitated by the change in the regulations, would that also be reimbursable under Medicare as long as it was necessary and proper?

A Yes.

Q Would the percentage of reimbursement in each of those examples that I have given you be the same?

A Yes.

Q Mr. Jansak, are you familiar with the provisions

of the Act and the regulations which prohibits the transfer of the cost of providing services to Medicare patients from Medicare patients to non-Medicare patients?

A Of course, yes.

Q Does that regulation and Act also provide that there shall be no transfer of the cost of rendering services to non-Medicare patients on to Medicare patients?

A It works both ways.

Q In the situation where a provider borrow money because of a cash flow problem that has nothing whatsoever to do with the Medicare reimbursement system, your have testified that he will get a percentage reimbursement for the interest costs, is that correct?

A That is correct. We look at why the loan was made. Was the loan made to reduce services for the institution? There can be lots of different Reasons, subjective and objective, of why a loan was necessary.

It could be as in this case, apparently there are large outpatient losses. It could be some sort of financial squeeze. The building has to be rebuilt. It could be -- cost limitation was mentioned today. It could be a host of reasons. You have to put in sprinklers in the old institution but as long as it is related to the production of services, we recognize it as a cost.

Q Therefore, the critical factor with regard to the prohibition of transferring costs is not what the cause of the need to borrow is, but rather whether the borrowed funds are being used to produce services for all, is that correct?

MR. IMBERMAN: I object to the form of the question.

THE COURT: Overruled.

A That's correct. We look solely to see the necessity for producing services to all patients.

Q Is it your opinion that in a situation in which Medicare reimburses for loans precipitated by events having nothing to do with Medicare is such patient reimbursement --

MR. IMBERMAN: Objection. Isn't that what you have to decide? It is a legal question.

THE COURT: What is the question?

BY MR. SCHAFFER:

Q Can you answer the question yes or no?

Is it your opinion that the payment of part of the interest costs in a situation where the need to borrow funds had nothing to do with the Medicare reimbursement system, is it your opinion that such reimbursement is an illegal transfer under the Act from non-Medicare patients to Medicare patients?

A No.

Q Is it your opinion that in the converse situation where Medicare partly reimburses, but not wholly, for interest costs where the need to borrow funds is precipitated by a change in the Medicare system, is that an illegal transfer from Medicare patients to non-Medicare patients?

A No.

Q Would you like to explain your reasons for those two answers?

A Whether a cost is allowable -- like I said before, it relates to whether it is a necessary and proper part of the production of services. That is, has the hospital spent the money properly in a health care environment.

The statement about shifting costs relates to our apportionment methodology.

It was alluded to before that we try to identify the costs which are routine and ancillary costs, and those costs that are outpatient costs because once we identify the area of the hospital or the production of services, we then try to determine what share is Medicare.

It has been alluded to Medicare nationwide on the routine services and about 30 per cent. 30 to 40

per cent of the hospital. We wish to reimburse services of 30 to 40 per cent. In the ancillary department it fluctuates upwards and downwards. We pay a different proportion in each ancillary area.

In the outpatient depatment a different utilization. It is lower and a lower share that we pay. That is what is meant by shifting costs.

If you put them together the outpatient cost will be shifted to the outcare reimbursement that would be shifting.

Q In layman's terms is it fair to say that the prohibition on shifting that we have been referring to is designed to make sure that Medicare pays its fair share of general hospital expenses?

A That's right. We wish to pay our aggregate share of -- our aggregate shares of insurance.

Q Are interest costs generally considered a general hospital expense for which reimbursement must be made according to the fair share of Medicare use?

A That's right. An allowable cost.

Q Mr. Jansak, you have heard a number of witnesses refer to working capital as part of the reasonable cost of doing business.

In your opinion is working capital part of the

reasonable cost under the Medicare system?

A Working capital cannot be a cost. It is a necessity in business, but it is not a cost.

You need to have a working capital for working capital purposes. You need to have some difference between the revenues you receive and your expenses. You can adjust that theoretically in two ways. One, by having a profit margin or, two, paying out your money slightly slower than you receive it.

Q At what point under the Medicare Act and regulations would working capital become a reasonable cost?

A If they had to borrow, obtain a loan, then it would become another loan for whatever purpose, the same as all interest costs.

Q In other words, you cannot have a reasonable cost unless there is actually a cost incurred, is th[illegible] correct?

A That's right.

Q Mr. Jansak, you referred before to the Medicare Hospital Trust Fund and to the Government's interest in keepings funds in there as long as possible to earn greater interest.

Would you explain briefly how this trust fund

works? Will you explain how payments are made in and out of it?

THE COURT: I do not think you have to go into that. I assume the longer they can hold on to the money, the greater interest they have on it.

MR. SCHAFFER: One further point, your Honor.

BY MR. SCHAFFER:

Q Mr. Jansak, when payments were being made out by three and a half-day lag, was there ever a danger during that time of depleting the trust fund?

A No.

MR. SCHAFFER: No further questions.

THE COURT: Okay, gentlemen.

MR. IMBERMAN: If your Honor please, I know your Honor wants to suspend in eight or nine minutes. My cross-examination will take substantially longer than that.

THE COURT: This man is going back to Baltimore. I assume that you and Mr. Schaffer spoek about it and you knew about it.

MR. IMBERMAN: I said I would take him out of turn. I am not going to bring the man back from Baltimore.

THE COURT: Go ahead.

CROSS EXAMINATION

BY MR. IMBERMAN:

Q Mr. Jansak, you have testified on direct examination concerning the factors which were considered by the department for which you work before the change in the regulation was promulgated, do you recall that?

A Yes.

Q Were those considerations published anywhere?

A They were mentioned in the preamble.

Q Where were they published?

THE COURT: What does that mean?

THE WITNESS: In the preamble to the notice of rule making, and in the final regulation there is some discussion.

Q Would you show that to me?

A If I would be given the exhibit.

THE COURT: He has asked for some of your exhibits.

Q Do you know which ones you are referring to?

THE COURT: When you find them, identify them for the record.

A An answer was given in July, July 16, 1975, Federal Register, Column 1, Page 29816, Paragraph 1.

Q May I see that?

Paragraph 1 covers about half of the length of the page. Is there a particular sentence or two or three that you consider as the answer to my question, and, if so, will you be good enough to read it into the record?

A There is a brief statement here that arguments have been made that the proposed payment schedule would severely hinder the cash flow of providers.

Q Is that the extent of the answer?

A No. I'm reading what the question is that we are answering to.

Q Go ahead.

A The sentence begins:

"However, careful consideration of the introduction of an average three-week payment lag into the PIP method demonstrated that such a lag compares favorably with the average lag and payment experienced by providers reimbursed under the regular interim payment procedures."

That is the answer.

Q Is that the only place where the defendants have published any reason for this change in the PIP method?

A No. I think it was also in the intermediary letters. I think, in fact, -- I would have to take a look.

I think it was in the September letter.

Q September?

A The September of 1973 intermediary letter.

Q That was before the regulation change was published, am I right?

A You asked me were there reasons given for the change to the new PIP 21-day schedule.

Q I asked you if what you just read was the only place where the department published the reasons why it was changing the regulation.

A The other one, the other letter was published also.

Q That was a proposal that was published a year and a half before the change was effective, am I right?

A You asked me if the reasons were published.

THE COURT: He said they gave the reasons when they initiated the proceedings as to why they were going to do it.

MR. IMBERMAN: If that is the answer, that is all right.

BY MR. IMBERMAN:

Q Can you show me where in '73 they published the reasons for making the change in the regulations?

A In addition to what I have read?

Q Yes, in addition to what you have already read.

THE COURT: Give him a copy of the September '73 intermediary letter.

MR. IMBERMAN: I think he has it in front of him, Judge. I have pointed it out to him.

MR. SCHAFFER: Your Honor, may it please the Court, I take it that plaintiffs' counsel is addressing himself to the issue of whether there has been adequate statement of reasons.

The documents in question are all part of the record at this time. Plaintiffs' counsel and myself I am sure will have some extensive arguments to make as to whether or not there is anything contained in these documents that constitute a sufficient statement of reasons under the APA.

I see no reason why the time of this Court and witness should be spent trying to run through all the documents now. They are in the record.

THE COURT: He said there were two places. He has identified one and I will let him see if he can identify the second.

Is there anything in that?

THE WITNESS: There does not appear to be, your Honor.

BY MR. IMBERMAN:

Q Do I take it what you have read, Mr. Jansak, is the sole place where the department published the reason for making the regulation, am I right?

MR. SCHAFFER: Objection, your Honor. This witness has had a few minutes to go through these things.

THE COURT: He is an expert. You called him. He ought to know where it is much better than you do.

A I was under the impression it was in one other place.

Q But you cannot find it now?

THE COURT: I will let him supplement the record later on.

Q Mr. Jansak, of the 800 hospitals, or the 600 hospitals that you said joined the new PIP system, how many of them were located in the City of New York?

A I wouldn't know.

Q How many of them were located in the greater metropolitan area of New York City?

A I would not know.

Q Have you any idea?

A I would assume since there were many, many hospitals under the old PIP, there would be few under the new PIP.

Q Isn't it true that there were only about four that joined the new PIP system in the City of New York?

A If you say so.

Q I'm asking you.

A I don't know.

Q Isn't it true that most of the hospitals which joined the PIP system when it was inaugurated in 1968 were located in the large metropolitan urban centers of the country?

A I know there was a concentration in New York. I think more sophisticated hospitals were the ones that took advantage of it. I think that's a fair conclusion.

You had to be more sophisticated to know the substantial uses of PIP in terms of cash flow.

Q Isn't it true that most of the voluntary hospitals in the City of New York joined the PIP system because it alleviated their need for working dapital?

A I could not answer that -- why they did it. Obviously since you got money faster and you were sophisticated, you would realize that it would give you morre free money faster.

Q Weren't you aware of the fact that most of the hospitals in the City of New York joined the PIP system because they needed working capital, and this would

alleviate their cash flow?

A No, because I was not concerned.

Q Just answer my question. If you were not, you were not.

A No.

Q Do you know that fact now?

A That that was the only reason?

Q That that was the main reason why they joined, because it helps to alleviate their working capital and cash flow.

A Since they got the money it gave them more cash. I mean that that is obvious.

Q Wasn't it the purpose of the PIP system to get money to hospitals as fast as possible?

A The basic purpose was to provide a predictability and a cash flow.

Q What do you mean when you say "predictability and cash flow"?

A That there is a check every week, and if the clerk is sick who is preparing the bills, the check still comes. You don't have a problem because the bill does not go out to the intermediary.

Q The hospitals know they can rely on the check every week.

A That's right. They didn't have to worry about whether the intermediary was performing adequately.

Q The check came from the intermediary, didn't it?

A Some of them process bills slowly.

Q Did you hear Mr. Ingram testify this morning?

A Yes.

Q Did you hear him testify that when Medicare started there was a great backlog of paper work, and in the hospitals and intermediaries' offices and the Social Security Administration, did you hear that testimony?

A That's what I thoguht he said, yes.

Q Did you hear him testify that the hospitals were not being paid on time because of the accumulation of this paper work?

A That's right.

Q Do you agree with that testimony?

A That's right. There was need for predictability of cash.

Q Did you hear him testify that he received a call from somebody in the Social Security Administration asking him what he thought about this idea that the man was advancing by PIP and giving the hospitals 1/52 of their annual money weekly and divorcing the payment from the paper work flow, did you hear that?

A Yes.

Q Do you agree with Mr. Ingram's statement?

A Which statement?

Q That statement, that it would make it more predictable, to divorce the payment of money from the processing of bills.

A That's right.

Q That was the purpose, was it not?

A That's right.

Q And isn't it true that one of the basic reasons of the regulations of your department states that the intermediary is to get moneys to the hospital as fast as it is expeditiously possible?

A Administratively feasible.

Q As expeditiously as possible.

A That statement is contained in the regulation description of the traditional interim payment procedure. That statement is contained in the regulation description of the traditional interim payment procedure. That statement is contained in the regulation describing the traditional interim payment procedure, and prepared in 1966 when the regulations were published.

When the PIP, when the new method was put in the regulations, it was published in a later date and

provided a specific payment schedule.

THE COURT: Is that answer supposed to mean that the 1968 regulation has no relationship to "administratively possible"?

THE WITNESS: No. It advises the intermediaries to work as promptly as possible mechanically, to have the clerk available to do the issuing.

THE COURT: Is this change that you put into effect now complying with that regulation?

THE WITNESS: We believe so because it provides a time schedule for an alternate schedule.

THE COURT: But as fast as administratively possible. You can do it in three and a half days.

Why do you have to change it to 21 days?

THE WITNESS: The "administratively feasible" is a directive in the second paragraph to the intermediaries' performance and not PIP payment.

THE COURT: I asked you that before, whether the words "administratively feasible" were in your opinion not related to the 1968 regulation. You said it was not.

THE WITNESS: Maybe I have forgotten. It was a part of the original interim payment procedure, the traditional.

THE COURT: As fast as "administratively possible"?

THE WITNESS: That's right.

THE COURT: And now you say when they came along and created PIP, that those words did not apply to PIP and, therefore, you can go back to 21 days without violating the regulation, is that what you are telling me?

THE WITNESS: I don't recally think that there is a contrast that way.

The administrative feasibility has directive to the intermediary claims processing. The PIP is an alternate to claims processing, and provides them to schedule the issuing of checks to the providers.

THE COURT: If you can do it for the last eight years this way, why do you have to change since you can administratively do it under this existing system '68?

THE WITNESS: The mechanics of issuing the check, the check can be issued daily or hourly. It is again as we viewed it, a mandate for intermediaries to work as fast as possible in their processing bills.

THE COURT: If a hospital could get a bill out to you every week for the week's services, when do you think it ought to be paid?

THE WITNESS: They are on a traditional billing

system and two people who can push it through. The hospital and the intermediary can push it through.

We don't wish to be responsible for any dilatory practices.

THE COURT: And three and a half days that exist up to now you say had absolutely nothing to do with PIP?

THE WITNESS: Well, PIP would have been weekly or biweekly. Most of them converted to the weekly option so that was not mandated, the three and a half-day figure. But that is how it worked.

THE COURT: "Administratively possible" in your view has absolutely no relationship to the three and a half-day payment in the past?

THE WITNESS: Yes.

BY MR. IMBERMAN:

Q Did you know that for almost eight years most of the hospitals in the City of New York which were on PIP were being paid with the three and a half day lag on the average between the date the services were rendered and the date of payment?

A Yes.

Q As a matter of fact, your department's administrative letter or inrermediary letter says that there is only a three-day lag, isn't that right?

A It depends on how you count.

THE COURT: What difference does it make?

MR. IMBERMAN: Okay.

Q And Blue Cross is your intermediary, am I right?

A Yes.

Q Your fiscal intermediary.

A Yes.

Q Blue Cross finds it administratively feasible to make payments to the hospital every week, isn't that so?

A We have already discussed it.

Q Answer the question.

A They issued checks every week, yes.

Q They found it administratively feasible to do so, didn't they?

A Certainly.

Q YOu knew that, didn't you?

A Yes. Yes.

Q Did you ever ask them whether it was not administratively feasible to send out checks every week?

A No.

Q Isn't it true that the change in the system was being promulgated because the department wanted to create a one-shot change and the cash flow out of HEW?

A I think that was part of it, but not all of it.

Q And after this one-time savings in whatever fiscal year the change was made, thereafter the cost to the Government would flow along exactly the same way, would it not?

A A substantial saving to the Government every year because the difference of $170 million every year, and the Government would receive that interest.

Q The Government would be paying out that money every year.

THE COURT: To save the interest on $170 million, the same that you people claim they have to pay the cost every year.

Q So what you are doing is shifting the cost of the interest that would be used to pay for the borrowed money, that money from the Government to the hospitals.

A You don't have to borrow money to do it.

Q Most of the witnesses here said they have to or cut back on their costs. You heard them, didn't you?

A Yes.

Q Have you seen Exhibit 1 which has been admitted in this case?

A Yes.

Q You have seen that many hospitals have negative working capital positions

A Yes.

Q And you have read, have you not, letters from many of the hospitals in the New York area complaining about the proposed change, that it would be costly to them and they did not have the working capital, isn't that so?

A I think as described here, they described it as to reasons other than the Medicare -- the Medicare program, their own problems.

Q They have problems though.

A Apparently they do, yes.

Q Does the change in the payment under the Medicare program have an adverse effect on the hospitals as far as their working capitals is concerned, and their cash flow?

MR. SCHAFFER: Objection, your Honor. He is not an expert on the hospitals' finances.

THE COURT: The answer is obviously yes.

A Yes.

Q Did the department consider that when it issued this regulation?

A It took a nationwide view of hospitals, yes.

Q Did it consider specifically the position of the voluntary hospitals in a large urban center like New York?

A I think they did, yes. I did.

I would say that Mr. Ingram described some $650 million of reimbursements to the area, and the plaintiffs' hospitals might have half a million dollars of reimbursements to the area. We are talking about $28 million, or depending on which number you want to settle for, and that put it in its proper perspective.

I thought that that ratio indicated the financial effect on the city hospitals as well as on the hospitals throughout the country. And that there would be a shift.

THE COURT: $28 million against the $500 million.

BY MR. IMBERMAN:

Q And you thought it was such a little amount that it did not matter?

A I don't think that is the way I viewed it. We thought the payment was being paid out inappropriately from the point of view of the Medicare program.

Q When was the decision made that these payments were paid inappropriately?

A When the secretary designed the final regulation.

Q In 1975?

A No, that was in '74. Whenever the final

regulation was.

Q For six or seven years the department had been paying on the weekly PIP system. What occurred at the end of the six years to make somebody decide that all of a sudden the payment was inappropriate?

A There was a lot of discussion as to whether the mechanism was appropriate, and whether it was paying out too fast, and whether it was increasing costs.

Every day every regulation is being reviewed from that point.

Q Was there some specific thing that came to your attention that made you consider whether you should change the system and save some money for HEW?

A What usually occurs is once a year there is a budget review, and that crystallizes ideas.

THE COURT: He has already admitted this.

Q If the original PIP program was incorporated in order to get money to the hospitals faster, your change now is reversing that and getting moneys to the hospitals slower, isn't that correct?

MR. SCHAFFER: Objection.

THE COURT: The answer is no, according to his own figures.

A More predictably, not necessarily faster. It

turned out to be a faster, yes.

Q Is it your statement that when the PIP system was organized in 1968 that the purpose there was not to get money to the hospitals faster than they had been getting it before, but only more predictably, is that your statement?

A It would have to be faster than the traditional billing cycles because they were failing, but the idea was you would pay them on a regular process so the flow would be predicable and faster than the chaotic situation which existed then.

Q And now making it slow.

A The chaotic situation was six years ago.

THE COURT: Let me ask you, Mr. Jansak, if it is true for argument's sake that all of the hospitals listed on Plaintiffs' Exhibit 1 which are members of the plaintiff association now has to borrow money for cash flow created by the delay, do you think that you should pay the interest on such borrowing?

THE WITNESS: We will consider that as another loan and they apparently have great loans. We will pay our share of that loan as well as the rest, yes.

THE COURT: This loan is being caused by your action and nobody else's.

THE WITNESS: Viewed in the hypothetical sense of our action alone, I do not think you could say it was traceable to us that you would necessarily have to borrow.

I do not think the fact that the payment cycle slows or speeds up results in the need to borrow money in a hypothetical situation.

THE COURT: You have live witnesses who swore here today that they will have to borrow.

They just do not have the money to meet the payroll and the vendors if you don't give them this weekly check. And they will have to go into the money market and borrow. You are causing them to do that.

That is not hypothetical. That is what they have said.

THE WITNESS: Yes.

THE COURT: Now that being true, you, having caused them to borrow, should not you pay the interest cost on the borrowing?

THE WITNESS: We do pay our share because we don't go into all substitive factors on each loan.

THE COURT: Shouldn't you pay the entire interest cost on that borrowing because you have created that cost in the Medicare area?

THE WITNESS: I guess if we moved to that idea, then we would have to look at why the other loans were obtained, and identify those that are not related to Medicare and then you would have that kind of a process if you

would subjectively analyze each loan and for those attributable for each patient.

THE COURT: You are sitting there on November 28, 1975 and everything has been taken care of until now and some can live and Monte Fiore can live and I don't know how Peninsula stays alive or Brooklyn Jewish stays alive from the figures, but somehow they are staying alive, and you come along and you force them to incur, you and nobody else, forces them to incur an additional expense which may put some under, but certainly recreates an additional cost.

Why shouldn't you pay for that because you are changing your procedures?

THE WITNESS: I would think that if you draw the analogy that we have done this--in effect, we have been subsidizing something we should not have been.

THE COURT: That is your problem. I am presented here with the case that you have done something before me now and they are complaining about it. What is your answer?

THE WITNESS: I think in that context that we have done something that they say caused now a medicare loan, and therefore, as part of that answer, we apparently possibly have based on their allegations have caused it, but I think the principle of production of the unit of services is the way you have to analyze the cost being incurred.

We do not have a system of analyzing each loan the hospital makes, whether it is for the out-patient department, something Medicare has a little share in as opposed to other loans. A research loan was mentioned here as being one of the activities the hospital engages in that Medicare is not responsible for and the hospital engages in many activities; the out-patient, in-patient and Medicare and the total of their services that produce the need or lack of need of a loan.

I don't think you can isolate it that they have to have a loan just because Medicare did something.

THE COURT: Go ahead.

BY MR. IMBERMAN:

Q You think it is in accordance with the statute for HEW by this change in regulation to deprive the hospitals of this cash flow so that they have to borrow money and pay interest, if they can borrow, and, therefore, increase the cost of hospitalization?

A I do not think the action requires hospitals to borrow money.

Q You heard the witnessese here, didn't you?

A That action by itself does not require the hospital to borrow money.

Q Didn't you hear the witnesses?

A I'm talking in the sense of one action by one vendor.

Q I am talking about these witnesses who testified and didn't you hear them say that?

A Yes.

Q Didn't you hear Mr. Ingram say that?

A He said that, right.

Q And wouldn't that increase the cost of hospital care in New York?

A As those situations were described to me, this action in PIP had little to do with their substitive problems.

Q You did not think paying interest would increase the cost of hospital care?

A I don't think so, no. It is another pressure on the hospitals' total line of cost, their payout schedules, their payments to the vendors, their payments to the employees and part of the total pressure.

Many of them described this morning the environment that hospitals live in.

Q HEW adds a little more pressure, is that right?

A Another concept in how the payment will be made.

Q More pressure.

A If a hospital is in a critical cash flow position, there is more pressure obviously.

Q You heard the witnesses, didn't you?

A Yes.

Q They are all in critical cash positions, aren't they?

MR. SCHAFFER: Your Honor, this is somewhat repetitious.

THE COURT: It is. Next question.

Q You testified on direct examination that somebody at HEW, perhaps you, thought that the old PIP system was inconsistent with the traditional system, and that is why you wanted to change it.

A Yes.

Q Wasn't it inconsistent in 1968 when you originally put it into effect?

A Obviously, and with hindsight someone else thought it was too inconsistent.

Q You mean nobody realized it was inconsistent with the traditional time?

A The PIP system was not a good seller. I think it was something aside from the interim payment procedure which was minor and not looked at in terms of cost consequence.

Q I am asking you whether anybody in 1968 thought that the PIP system, when it was enacted, was inconsistent with the traditional system.

A Obviously they would not inaugurate it.

Q You are not answering the question, sir.

A I can't make judgments about what is in people's minds.

Q You were not there?

A I was in the branch, yes.

Q Did you have anything to do with the PIP system and inaugurating it?

A No.

Q Did you ever hear anybody discuss it at that time?

A Of course.

Q Did you ever hear anybody say it was inconsistent with the traditional system?

A The idea was that it was a different kind of system.

Q Inconsistent with the traditional system?

A Inconsistent in what way?

Q Are you now changing your answer of five minutes ago?

A No. I termed it in a difference in lag. If

you are talking in terms of the difference in lag at that time, it was a shorter lag because the other lags were long.

Q Are you telling me that the word "consistent" as you have used it on direct examination referred only to shorter lag?

A That's all we have been talking about. What else are we talking about?

Q Okay. That was approved in 1968.

A Yes.

Q And now that same inconsistency in 1974, according to you, is the reason for the change.

A That's right.

Q Somebody has changed his mind in the department, hasn't he?

A It is obvious.

Q Why?

A Because the concern became apparent as PIP expanded that there is a lot of money going into PIP because of reanalysis of our entire mechanism.

Like I said, a yearly thing of reanalyzing our views. It became apparent that this procedure, this system, was very inconsistent with the traditional billing system that had developed.

THE COURT: And putting a greater burden on your payout, and you were paying out money faster than you expected to pay it out?

THE WITNESS: That's right.

BY MR. IMBERMAN:

Q You also said it was inconsistent with what Blue Cross and Medicaid were doing, and that was another reason why you wanted to change.

A Blue Cross and Medicaid, during that period of time, did not have anything like PIP or advance payments.

Q What is the period of time?

A '66, '68.

Q When you changed?

A When we changed, yes, sir.

Q You said one of the reasons why you changed is because neither Blue Cross nor Medicaid was doing anything like what you were doing.

THE COURT: That answer was countrywide, nationwide.

A. Nationwide.

Q But you are aware of the fact that Blue Cross and Medicaid in New York were doing much to alleviate the hospitals' working capital positions, weren't you?

A I think that might be because of their large

out-patient obligations.

Q I would like you to answer my question, sir.

A Yes, they were doing it.

MR. SCHAFFER: I object, your Honor. I object to plaintiffs' counsel saying, "doing much to alleviate the cash flow payment."

THE COURT: Obviously the advance payment of Blue Cross was alleviating the cash flow problem.

Q You knew what was happening in New York, didn't you?

A Today?

THE COURT: He said he did.

Q Did you consider that Medicare ought to bear its share of helping the voluntary hospitals in New York with their working capital problem by continuing PIP under the old system?

A I think we viewed how we would help New York's problems and hospitals throughout the country. We don't have separate systems for separate areas. We have one unified reimbursement system for the country which we think provides adequate reimbursement.

Q Haven't you had a variety of reimbursement systems under Medicare for many years?

THE COURT: Depending on locality?

A No, not under Medicare.

Q You have had a variety of systems, have you not?

A Only one system.

Q Reimbursement plans?

A There have been no radical changes.

Q I am not asking about radical changes.

A We have made changes of course.

Q Have there been different ways of paying hospitals?

THE COURT: Wait a minute. Wait a minute. You are leaving the point. The point is whether their system, whatever it may be at a particular time, should or should not take into consideration the local problems. That is the question. Can you answer that?

In other words, if you had a system of payment, no matter what it was at a particular time, was it uniformly or did you have differences of problems at the same time?

THE WITNESS: No. Medicare is always a national policy and never any shifts in the methodology.

THE COURT: Okay. He has answered it. Uniform.

Q Does the statute provide in reimbursing hospitals that the secretary can consider the problems of each hospital from time to time?

A I've never seen that in the statute.

Q Or a regulation that talks about that?

A Not the way you are describing it. If "consider" means to analyze their problems and try to make your own system better, of course.

Q Is there any provision in the statute or regulations which permits the secretary to make allowances for the money which hospitals are paid, or the way in which they are paid, depending upon their individual problems, their areas, the time of year even?

A The only thing approaching that is cost limits which are recreated to certain geographical areas.

Q Anything else?

A Other than that I think the system is uniform. Of course you have separate cost reporting years.

Q Do I take it that one of the reasons you say you made this change was because the hospitals were getting too fast?

A Yes.

Q And you wanted to slow it down?

A We wanted to make the two systems more constant with each other.

Q Did you at one time have a system you called Current Financing?

A Yes.

Q What was the purpose of that system?

A The purpose of that was as the program got under way to provide billing because of the problems, and the entire Medicare processing and handling and a process similar but not quite like Mr. Ingram described in the program.

Q Was that inaugurated prior to the PIP system?

A Oh, yes, that was from the beginning of the program.

Q And that was the way of getting hospitals money faster because the paper work was clogging the flow of money back, is that right?

A It was a permanent loan. That would be the easiest way to describe it.

Q A permanent loan?

A Yes.

Q What amounts?

A There was a formula based on the bill processing system and intermediary processing system, up to 30 days maximum.

Q In other words, you would loan the hospitals up to 30 days of their Medicare payments?

A It was concurrent, a formula designed to provide

the money concurrently with the time the services were provided.

I don't think you would call it a loan, but the bill would be coming in later.

Q You called it a loan.

A I will withdraw that.

Q It was a method of getting the hospitals money concurrent with their provision of the services, am I right?

A Right.

Q So, in effect, the hospitals provided services for Medicare patients today would get paid today, right?

A You could say that I think.

Q Wasn't the purpose of that to alleviate the cash flow problems that the hospitals had?

A Naturally any payment would have that effect, yes.

Q Wasn't that the purpose of current financing?

A To provide the money promptly until the bill was processed.

Q To alleviate the hospitals' cash flow problems, isn't that so?

THE COURT: I think you are saying the same thing in different words.

MR. IMBERMAN: It is hard to pin this man down.

THE COURT: He said you get paid and it is the same thing you are saying.

MR.IMBERMAN: I am driving at the purpose. I know what the effect was.

THE COURT: To get the money to the hospital as quickly as possible. Next question.

Q After you inaugurated the PIP system you subsequently terminated Current Financing, isn't that so?

A Yes.

Q Because PIP really took the place of it, isn't that so?

A Never did. PIP was never very large on the national scale, before or after, old or new.

Q Why did you terminate Current Financing then?

A It is described in the preamble as that--the authority that now--that the program had stabilized, that the hospitals' intermediaries were billing faster and hospitals no longer needed that cushion, and the Federal Government did not have to lose the interest on that money.

Q Was that really the reason?

A That's the reason in the preamble.

Q But to your knowledge was that the reason?

MR. SCHAFFER: Objection, your Honor.

THE COURT: I think you have to take what the Government stated was the reason.

BY MR. IMBERMAN:

Q Was there also something called a 2 per cent allowance that you gave to hospitals?

A Yes.

Q When was that inaugurated?

A At the beginning of the program.

Q Was that also to help the bospitals with their cash flow problems?

A Not the way we have been talking about it today.

Q What was the purpose then?

A The purpose at the time was conceptually to provide money that supposedly the apportionment and cost finding and reporting system did not account for in the Medicare process.

Q That would include working capital costs?

A It includes anything the hospital needs money for.

Q Working capital costs?

A Sure.

Q After the PIP program was inaugurated, did you terminate the 2 per cent allowance?

A The 2 per cent was a plus factor that was --

Q Mr. Jansak, why don't you answer the question?

A Yes, of course. After PIP, yes. Right.

Q Did you do do that because PIP really took its place and giving the hospitals a flow of cash, and you did not need the 2 per cent any more?

A No. PIP, like I said, for a long period of time was never part -- a significant part of the payment of procedure.

Q Mr. Jansak, are you familiar with the section of the statute which provides that in the making regulations the secretary, or concerning Medicare, the secretary should take into consideration principles applied by national organizations?

A Sure.

Q And Blue Cross is a national organization.

A Blue Cross Association and their individual plans.

Q Blue Cross in New York, the largest one of the Blue Cross plans throughout the country.

A I would not know. It might well be.

Q When you were considering this change in the PIP regulation, did you take into consideration that Blue Cross in New York was depositing money in advance with the

hospitals so they would have working capital?

A That is not the national representative. The Blue Cross of New York would not be the one consulted.

Q You did not talk to them about it?

A I don't know. Maybe we did.

Q But you did not take into consideration what Blue Cross in New York was doing?

A We would not ordinarily, no. We don't talk to individual plans by contract. We deal with the Blue Cross in Chicago.

Q Did you ask them what the Blue Cross plans around the country were doing?

A I think we solicited their views on these comments numerous times.

Q What did they say about the proposed change in this regulation?

A I would have to go back and look.

Q Don't you recall?

A No.

Q Didn't you prepare yourself to come here and testify?

THE COURT: Come on. Don't argue with the witness.

A I prepared myself for one day, yes.

Q Could you go back and on Monday let us know what the Blue Cross organization said?

A Yes.

Q Would you be good enough to do that, and then communicate that to the United States Attorney, Mr. Schaffer?

A Yes.

Q Thank you very much.

Isn't it true that the statute says that in making regulations for the payment of hospitals, the secretary may provide for using different methods in different circumstances, and may provide for the determination of costs on any basis that he claims appropriate?

A I think that is a fair statement.

MR. ADAMS: May we adk what regulation you are referring to?

MR. IMBERMAN: Are you trying this case?

THE COURT: Mr. Imberman, he is the head of the Civil Division. His appearance has been noted on the record.

He has a right to do that.

Answer the question.

MR. IMBERMAN: I am not sure what the question is.

THE COURT: He is asking you for the citation

of what you are reading from.

MR. IMBERMAN: 1395, Subdivision (v) 1(a), about in the middle of the page.

BY MR. IMBERMAN:

Q Wouldn't you consider that under that part of the statute which I just paraphrased, that an exception could be made for New York because of the special circumstances in New York?

A Not under the principles of reimbursement as they are issued.

Q Where are those principles found?

A 20 CFR 400.

Q What you are quoting to me is the regulation, am I right?

A And the statute that you are reading from says that the secretary shall issue principles of reimbursement to describe what the principles are.

Q I understand that, but the secretary could issue a regulation under the statute.

MR. SCHAFFER: Your Honor, I would like to object at this point.

This statute does not deal with methods of payment, but costs and determinations thereof. I see no reason why he should badger the witness by using a mis-

summary of the statute.

MR. IMBERMAN: The statute does talk about the secretary providing for the determination of cost, but it does seem to me it follows. Quite likely after he determines how costs are to be determined, he makes a regulation. How he decided under this system, and paying somebody else under another system, that was the thrust of the question.

THE COURT: I sustain the objection.

MR. IMBERMAN: I have no further questions, your Honor.

MR. SCHAFFER: Your Honor, I will make it brief.

REDIRECT EXAMINATION

BY MR. SCHAFFER:

Q Mr. Jansak, earlier you made reference to the preamble to the July promulgation of the regulation. You read some language from Paragraph 1 which you felt --

MR. IMBERMAN: May I have the date of that thing you are reading from?

MR. SCHAFFER: This is the preamble in 40 Federal Register, page 29816. The date of the Federal Register is July 6, 1965.

MR. IMBERMAN: I have it.

Q You read some language from Paragraph 1 which

you felt indicated some of the reasons for the promulgated regulation.

Further down in that same paragraph, the last sentence, it says:

"The time period for intermediaries to adjust and implement the revised schedule is necessary to effect uniformity with respect to the interval of payment as soon as administratively feasible."

Woul say that that further affects the adoption of this regulation?

MR. IMBERMAN: I object to this question, your Honor. I think it is unfairly leading.

THE COURT: Sustained.

Next question.

BY MR. SCHAFFER:

Q Mr. Jansak, is there anything further in that paragraph that you feel reflects the purpose of the promulgated regulation?

MR. IMBERMAN: Same objection, your Honor.

Q Paragraph 1 of the preamble to the regulations which further affects what you read previously the purpose of that regulation.

MR. IMBERMAN: Same objection, your Honor.

THE COURT: Overruled.

A The entire preamble's purpose is to place the rationale in there.

THE COURT: You have testified on direct examination the reasons why this regulation was adopted.

You were asked on cross-examination:

"Where did you state that in your promulgation?"

And you have referred to a sentence in that document you have in your hand.

You are now being asked if there is any other language that you would like to add to what you have already told us.

A There is other language in this preamble that describes part of the entire conversion procedure.

THE COURT: That is not what we are talking about. We are talking about. We are talking about the reason for the change.

THE WITNESS: I would have to say that the last sentence also carries the theme of that other sentence that I quoted.

THE COURT: Read it.

THE WITNESS: "The time period for the intermediary to adjust and implement the revised schedule is necessary to effect uniformity with respect to the interval of payment as soon as is

administratively feasible."

THE COURT: All right.

MR. IMBERMAN: If your Honor please --

THE COURT: He is being asked a question and he is giving an answer.

MR. IMBERMAN: I move to strike it.

THE COURT: Overruled.

MR. IMBERMAN: Very good.

BY MR. SCHAFFER:

Q Mr. Jansak, earlier the plaintiffs' counsel made reference to a regulation which provides that intermediaries shall make payment as promptly or as often as it is expeditiously -- as is administratively feasible.

When was that regulation promulgated?

A 1966 or late '65.

Q At the time that it was promulgated what was the original existing interim payment system?

A The traditional billing practice system.

Q Under that system it is true, is it not, that payments would not be made until the intermediary would Have an opportunity to process the billings?

A Yes.

Q Isn't the purpose of that regulation then to direct the intermediary in processing the bills under the

traditional reimbursement method and not to wait until the end of the month as they might do since they only have to pay monthly, what was the purpose of that regulation?

A It was to have them issue, as I said before, to act promptly and diligently when the bill was received, and to promptly and diligently make a reimbursement based on the rates discussed in there so that at the end of the year you are essentially in a neutral position.

Q Would such a directive, that is to process payments on bills as expeditiously as is administratively feasible, would such a regulation have any applicability to a system where payments are being made on a periodic basis at a set level?

A They are not related concepts.

Q Why would one have no applicability to the other?

A Under the traditional billing there is a clerical operation that is needed each and every day to analyze the bill that comes in from the provider to determine the number of patient days, and determine the interim rate and make a multiplication of each individual bill.

With PIP you only do that once a year. The same things you do with PIP is done once and the important thing is to send the check on the agreed to schedule with

occasional revision.

Q Mr. Jansak, earlier you heare his Honor make a suggestion that perhaps the Medicare system ought to pay 100 per cent of the interest cost on loans that the New York area hospitals might need to obtain due to the change in the regulations.

Would the payment of such 100 per cent of the interest cost be mandated by the present act and regulations?

A We would have to develop --

MR. IMBERMAN: If your Honor please, aren't you the one who has to decide this?

Q In your opinion is such payment required by the present act and regulations?

A Oh, no, it would not be. Not 100 per cent, no. In fact, we don't -- everything is subject to apportionment, the basic concept in regulations.

Q In order to effect --

THE COURT: That does not seem to hold true, does it? If your total amount of expenditures is $100,000, and you have 43 per cent of the patient days, you pay $43,000. That means you are paying every cent of what you --

THE WITNESS: I think I said it is an allowable

cost which means it is part of the hundred dollars and reimbursed subject to the apportionment share.

THE COURT: You are paying the hospital every cent they expended to maintain your patient.

THE WITNESS: That's right.

THE COURT: And you are giving them an additional cost.

THE WITNESS: The theory of the cost being incurred is the total cost being incurred by the hospital. And then through cycle or accounting theory, we determine what our aggregate share is of the total provision of services.

It is on all of them during the year and you determine the ratio.

THE COURT: Go ahead.

Next question.

BY MR. SCHAFFER:

Q Under the system then the percentage of reimbursement is the percentage of overall operating cost, and not item by item, is that correct?

A It is divided between what we call cost centers. What is an inpatient area, an area of similar production and separate segregation and ancillary services, and out-patient, that is a separate segregation. And then a

portion of those to determine what our share is.

Q In any event, it is your opinion then, is it not, that the payment of 100 per cent of the interest costs that might be occasioned by this change in regulation, would be something inconsistent with the present reimbursement system?

A It would be inconsistent with the way the regulations are written.

Q Earlier you described the old PIP system as being set up in part because of the chaotic situation of the traditional reimbursement method back in 1968, is that correct?

A Yes.

Q At the time that the weekly PIP system was set up, was it intended that this would be the permanent system, or was it anticipated that it would help further revision?

A I can only answer that nearly everything we do is revise sooner or later.

Q Plaintiffs' counsel has made reference to the regulation which provides that the systems of national organization s such as Blue Cross should be taken into consideration by the agency in establishing its regulations.

In your opinion does that require Medicare to follow or to imitate each of the practices of such national organizations?

MR. IMBERMAN: I object to the question.

THE COURT: Overruled.

A The word "consider" is to read, analyze, concur or not concur.

Q In fact, isn't the PIP system, biweekly or weekly, different from anything the national organizations have?

A I don't think any of them have anything like PIP. I don't know. I would have to let somebody else speak for the Blue Cross Association.

Q Plaintiffs' counsel has asked you whether the Blue Cross of New York specifically was consulted.

Isn't it a fact that for official purposes the fiscal intermediary is National Blue Cross and not Blue Cross of New York specifically?

A Right. We have comments from Blue Cross and Blue Cross in turn solicits comments from the plans they wish to solicit, and we receive the ones from the Blue Cross Association, and no classification of where the ideas came from.

Q But for contractual purposes the fiscal inter-

mediary is Blue Cross in Chicago, is that correct?

A Yes.

MR. SCHAFFER: Your Honor, the defendants have no further questions.

MR. IMBERMAN: I apologize, your Honor, but may I ask your indulgence for two or three minutes?

THE COURT: Go ahead.

RECROSS EXAMINATION

BY MR. IMBERMAN:

Q You testified a little while ago about the purpose of the regulation 405.454(b) which is the one that talks about intermediaries making payments on the most expeditious --

A Yes.

Q You said that regulation was adopted in 1966.

A Or late '65, yes.

Q And you testified about the purpose of it.

Did you have anything to do with the drafting of this?

A I was not in Provider Reimbursement at that time.

Q Did you have anything to do with the drafting of this regulation?

A No.

Q Did you have any access to the input of the reasoning by the draftsman?

A No.

Q What is the basis for your answer as to the purpose of this regulation?

A Seven years of experience.

MR. SCHAFFER: This witness has been qualified as an expert.

THE COURT: He said he knew nothing about it.

MR. IMBERMAN: It is not necessary for him to be there at the time.

THE COURT: You did not listen. Mr. Imberman asked the last question of what the basis for his knowledge was. We are going to get it.

A That is seven years of experience and interpretation of what the regulations are and their preparation.

Q Your seven years of exprience after now tells you what the purpose of the draftsman was in 1965?

A The objective purpose as articulated in words and not in his mind, but in words written there.

Q And the words are --

THE COURT: He went over this on your cross-examination.

Q Do you know the amount of money that is paid

by Medicare under the PIP system in the City of New York?

A I gave a calculation. I think it is about a half a billion dollars.

Q I have been informed that it is $800 million. Wo uld you accept that?

A Mr. Ingram said $800 million.

Q He told me that that is low. But do you know that this represents 80 per cent of the payments made under Medicare in the City of New York?

A Under Medicare?

Q Yes.

A It should be more than 80.

Q Do you think it is 90?

A Sure. Everything is in there except outpatient. I would say it is 95 or more.

Q I think you misunderstood me. Do you know that payments made under the PIP plan, the total payment made to hospitals under the PIP plan represents about 80 per cent to all the Medicare payments made in the City of New York?

A You are talking about Part B hospitals?

Q Hospitals.

A Inpatient hospital services, and PIP would be the totality of payment to a provider except for the final

payment.

Q All the hospitals in the city?

A Excluding those on -- I am sorry -- I would not know.

Q You don't know. All right.

Is there somewhere in your office where there is written data or a date upon which your studies are based for the change in the regulation?

A They were based upon regular studies turned out quarterly or since the program began.

Q Was there a specific study made in connection with the proposed change?

A To determine the bill cycle, no.

Q In other words, there is nothing in writing by way of a study which is the basis for the change in the regulations?

A No, sir. There are thousands of things in writing, but their studies are periodic on what their traditional billing time is.

Q Is there a specific study you made for the purpose of analyzing whether or not the PIP system should be changed?

A No. There did not have to be one.

Q There is none?

A That's right.

Q Do you know that in some time in 1975 the effective date of the change was moved from about December 1st of 1975 to May 31, 1976?

A That was the speed with which we would recover or make the conversion. That was a stretch-out in the convrsion period, yes.

Q Did that stretch-out lessen the effect on the hospitals' working capital in any way?

A Oh, yes. I would think so.

Q Did they lose a little bit of money over a period of 12 weeks or so rather than losing it all at once?

A Right.

Q But at the end of the year the same problem, they have the lost the totality of the money.

A They had trouble adjusting payment to employees and vendors, and they needed more time to adjust.

Q You are not answering the question.

(Question read.)

A What we alleviated is the speed at which they would convert, and that's all.

Q By May 31, 1976 they have the problem and they have lost all the money, isn't that so? The stretch-out has not been alleviated at all.

A The same problem as the other hospitals. . The regulation change you refer to only talks about the stretch-out.

Q It does not alleviate the loss of the money, does it?

A Right.

MR. IMBERMAN: No further questions.

THE COURT: Thank you.

You may step down.

(Witness excused.)

THE COURT: Do the defendants rests?

MR. SCHAFFER: The defendants rest, your Honor.

THE COURT: How much time do you want for briefs?

MR. IMBERMAN: May I have a week, your Honor?

THE COURT: here is a temporary restraining order in effect until December 1st. I will extend it for ten days.

A week from today would be December 5th. I think you have to have the brief in on the 5th. December 5th for briefs on both sides.

MR. IMBERMAN: Thank you, your Honor.

THE COURT: That is all.
(Hearing concluded.)

WITNESS INDEX

Name	Direct	Cross	Redirect	Recross
James C. Ingram	10	31	53	
(Recalled)			145	
Irwin Birnbaum	58	78	90	91
Philp C. Abrams	97	110	114	115
Leo Hellman	123	130	131	
Peter B. Terenzio	132	139		
John W. Jansak	149	182	219	228

EXHIBIT INDEX

Plaintiffs	Identification	In Evidence
1		22
2		95

Plaintiffs' Exhibit 1

[SCHEDULE OF PIP PAYMENTS]

PIP HOSPITALS	Current Assets	Current Liabilities	NET	Weekly PIP Payment	[illegible]	[illegible]
[illegible]	$ 4,446,550	$ 2,847,125	$ 1,599,425	$ 105,900	$ 317,700	[illegible]
[illegible] ISRAEL	13,764,734	12,841,903	922,831	327,100	981,300	186.34
[illegible]	5,531,902	5,274,378	257,524	147,600	442,800	171.95
[illegible] LEBANON	1,222,874	1,195,341	27,533	62,700	188,100	603.18
ROCKDALE	5,607,556	6,137,883	(530,327)	202,700	608,100	(114.67)
ROCKHAVEN	13,340,754	7,799,148	5,541,606	293,200	879,600	15.87
BROOKLYN	2,571,432	1,289,140	1,282,292	59,500	178,500	13.92
CALEDONIAN	5,830,134	3,874,293	1,955,841	157,600	472,800	24.17
CENTRAL SUFFOLK	3,992,469	1,258,171	2,734,298	71,700	215,100	7.87
COMMUNITY GLEN COVE	1,749,465	641,222	1,108,243	41,600	124,800	11.26
COMMUNITY LIBERTY	3,551,817	1,316,779	2,235,038	84,300	252,900	11.32
COMMUNITY MONTICELLO	536,515	609,215	(72,700)	21,500	64,500	(88.72)
CRANDALL	471,694	779,858	(308,164)	15,700	47,100	(15.28)
DOBBS FERRY	1,270,318	615,362	654,956	26,100	78,300	11.96
DOCTOR'S, N.Y.	312,380	99,275	213,105	10,800	32,400	15.20
DOCTOR'S, STATEN ISLAND	5,817,111	2,276,513	3,540,598	103,900	311,700	8.80
EASTERN LONG ISLAND	1,242,971	344,944	898,027	50,900	152,700	17.00
ELMER & FIFTH	1,020,281	567,604	452,677	30,600	91,800	20.28
FLUSHING	9,975,530	11,195,656	(1,220,126)	137,100	411,300	(33.71)
FRENCH & POLYCLINIC	2,545,921	2,568,425	(22,504)	112,900	338,700	(1505.07)
GOOD SAMARITAN SUFFERN	7,824,748	21,466,304	(13,641,556)	147,300	441,900	(3.24)
GOOD SAMARITAN, W.I.	3,2[illegible]421	1,674,366	1,551,055	61,300	183,900	11.86
HOSPITAL FOR SPECIAL SURGERY	3,2[illegible]948	1,250,132	2,046,316	77,100	231,300	11.30
HOSPITAL OF THE HOLY FAMILY	10,041,823	2,104,382	7,937,441	65,200	195,600	2.46
HUNTINGTON	880,464	1,965,314	(1,084,850)	46,800	140,400	(12.94)
JAMAICA	4,984,775	2,107,733	2,877,042	89,700	269,100	9.35
JEWISH OF BROOKLYN	3,740,113	4,734,298	(994,185)	90,200	270,600	(27.22)
JEWISH MEMORIAL	9,229,589	13,691,809	(4,462,220)	194,300	582,900	(13.06)
LUNG DISEASES	2,631,508	4,705,905	(2,074,397)	91,100	273,300	(13.18)
KINGSBROOK	4,298,626	3,845,389	453,237	91,800	275,400	60.76
LAWRENCE	11,269,356	13,785,985	(2,516,629)	175,300	525,900	(20.90)
LENOX HILL	3,664,990	1,211,741	2,453,249	91,500	274,500	11.19
LINDEN GENERAL	9,771,795	8,902,778	869,017	357,200	1,071,600	123.31
LOCAN, ARTHUR, C.	266,024	1,150,772	(884,748)	-	-	-
LONG BEACH	2,604,019	7,398,012	(4,793,993)	50,400	151,200	3.15
LONG ISLAND COLLEGE	1,860,171	973,418	886,753	97,400	292,200	32.95
LONG ISLAND JEWISH HILLSIDE	24,500,154	26,755,133	(2,254,979)	258,700	776,100	(34.42)
MADISON HOSPITAL	14,003,585	13,559,557	444,028	292,500	877,500	197.62
MAIMONIDES	389,439	1,012,431	(622,992)	19,500	58,500	(9.39)
MANHATTAN EYE,EAR & THROAT	9,147,663	10,522,090	(1,374,427)	303,100	909,300	(66.16)
MARY IMMACULATE	2,237,295	469,790	1,767,555	49,300	147,900	8.37
MEDICAL	5,262,186	13,357,082	(8,094,896)	102,400	307,200	(2.80)
MEDICINA	1,314,136	1,192,550	121,586	30,100	90,300	74.27
				$4,763,600		

Kingsbrook Medical Center -Kingsbrook Chr.Div.
L.I. Jewish - L.I. South Shore
Hospitals which are not members of the Greater New York Hospital Association (GNYHA)

	PIP HOSPITALS	NET WORKING CAPITAL AS OF 12/31/74 Current Assets	Current Liabilities		REDUCTION IN PIP PAYMENT Weekly PIP Payment	3X5	% of Col. 6 to 3
	FATHER, JOHN T.	$ 2,544,105	$ 939,990	$ 1,604,115	$ 63,000	$ 189,000	11.78
3	MEMORIAL HOSPITAL, GREENE	1,744,864	1,202,988	541,876	-	-	-
	MEMORIAL, N.Y.	17,616,885	14,623,467	2,993,418	296,800	890,400	29.75
3	MERCY	4,390,917	2,762,069	1,636,848	84,800	254,400	15.54
	METHODIST, BROOKLYN	5,255,469	3,126,231	2,129,238	225,500	676,500	31.77
	MISERICORDIA	3,360,054	3,579,357	(219,303)	120,200	360,600	(164.43)
	MONTEFIORE	26,122,272	17,260,714	8,861,558	856,700	2,570,100	29.00
3	MOUNT EDEN	406,278	554,251	(147,973)	34,700	104,100	(70.35)
	MOUNT SINAI	28,262,442	20,688,498	7,573,944	570,900	1,712,700	22.61
3	NASSAU	4,869,254	3,002,657	1,866,597	133,300	399,900	21.42
	NEW ROCHELLE	3,424,423	1,134,925	2,289,498	123,300	369,900	16.16
	NEW YORK	27,281,301	8,841,297	18,440,004	460,700	1,382,100	7.50
	NEW YORK INFIRMARY	3,101,284	2,856,679	224,605	83,800	251,400	111.93
3	NORTHERN DUTCHESS	616,933	284,732	332,201	17,500	52,500	15.80
3	NORTH SHORE	6,507,522	4,754,785	1,752,737	145,500	435,000	24.82
3	NYACK	3,873,282	1,892,488	1,980,794	93,400	280,200	14.15
3	PARKCHESTER	1,183,980	2,135,781	(951,801)	29,100	87,300	(9.17)
3	PARKWAY	2,021,599	1,385,418	636,181	98,200	294,600	46.31
3	PEEKSKILL	1,946,924	1,302,998	643,926	24,100	72,300	11.23
	PENINSULA	5,096,023	3,144,473	1,951,550	145,500	436,500	22.37
3	PHELPS	2,529,680	2,535,167	(5,487)	70,200	210,600	(3838.16)
	PRESBYTERIAN	26,759,151	13,249,703	13,509,448	438,400	1,315,200	9.74
3	PUTNAM COUNTY	1,577,034	1,171,137	405,897	44,300	134,400	33.11
	RICHMOND	2,086,579	2,440,839	(354,260)	65,900	197,700	(55.81)
	ROOSEVELT	10,764,414	12,964,477	(2,200,063)	218,000	654,000	(29.73)
3	ST. AGNES	2,317,472	1,649,611	667,861	61,100	183,300	27.45
	ST. BARNABAS	7,375,532	2,892,786	4,482,746	110,900	332,700	7.42
3	ST. CHARLES, PORT JEFFERSON	3,789,184	1,561,773	2,227,411	53,100	159,300	7.15
	ST. CLARES	5,945,970	7,114,634	(1,168,664)	205,700	617,100	(52.80)
3	ST. FRANCIS, ROSLYN	4,196,516	5,696,250	(1,499,734)	98,600	295,800	(19.72)
	ST. JOHN'S EPISCOPAL	5,900,811	2,858,656	3,042,155	98,600	295,800	9.72
	ST. JOHN'S, QUEENS	9,337,554	4,867,591	4,469,963	126,200	378,600	8.47
	ST. JOHN'S, SMITHTOWN	5,900,811	2,858,656	3,042,155	38,300	114,900	3.78
3	ST. JOSEPH'S, YONKERS	1,518,386	864,047	654,339	41,200	123,600	18.89
	ST. LUKE'S, N.Y.	13,286,945	8,295,291	4,991,654	245,800	737,400	14.77
	ST. MARY'S HOSP. BROOKLYN	6,618,485	11,712,243	(5,093,758)	39,500	118,500	(2.33)
	ST. VINCENT'S, N.Y.	5,623,648	4,204,496	1,419,152	324,800	974,400	68.66
	ST. VINCENT'S, S.I.	3,965,351	3,367,574	597,777	107,400	322,200	53.90
	ST. VINCENT'S, WESTCHESTER	1,591,871	431,176	1,160,695	12,400	37,200	3.21
3	SOUTHAMPTON	1,880,199	645,475	1,234,724	58,000	174,000	14.09
3	SOUTH NASSAU	4,621,573	1,913,554	2,708,019	111,800	335,400	12.39
3	SOUTHSIDE	4,079,844	3,384,393	695,451	102,200	306,000	44.00
	STATEN ISLAND	5,662,484	4,691,909	970,575	106,700	320,100	32.98
					6,385,000		

280a
Plaintiff's Exhibit 1

	PIP HOSPITALS	NET WORKING CAPITAL AS OF 12/31/74 Current Assets	Current Liabilities		REDUCTION IN PIP PAYMENT Weekly PIP Payment	3X5	% of Col. 6 to 3
	TRAFALGAR	$ 352,850	$ 1,533,064	$(1,180,214)	$ 40,600	$ 121,800	(10.32)
3	UNITED	3,437,688	1,526,278	1,911,410	115,600	346,800	18.14
	UNIVERSITY	19,273,829	20,696,456	(1,422,627)	271,400	814,200	(57.43)
3	UNIVERSITY HEIGHTS	319,533	338,720	(19,187)	6,500	19,500	(101.63)
3	WHITE PLAINS	2,063,166	1,322,348	740,818	74,600	223,800	30.21
	YONKERS GENERAL	1,699,359	1,592,607	106,752	55,800	167,400	156.812
3	YONKERS PROFESSIONAL	871,403	1,357,125	(485,722)	54,300	162,900	(33.54)
	SUBTOTAL				$11,768,300	$35,304,900	
	Hospitals which are not members of GNYHA				(2,311,200)	(6,933,600)	
	TOTAL				$ 9,457,100	$28,371,300	

281a
Plaintiff's Exhibit 1

Plaintiffs' Exhibit 2

[INTERMEDIARY LETTER NO. 75-58 DATED OCTOBER/1975]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SOCIAL SECURITY ADMINISTRATION

BALTIMORE, MARYLAND 21235

REFER TO:
IHI-324

ADVANCE COPY

October 1975

PART A INTERMEDIARY LETTER NO. 75-58

SUBJECT: Periodic Interim Payments (PIP) - Conversion from Weekly to Bi-Weekly Cycle

General

Enclosed is a copy of the final regulations concerning Periodic Interim Payments (PIP) as published in the July 16, 1975, Federal Register and the Notice published in the September 2, 1975, Federal Register which changed the date by which full implementation of the regulations must be accomplished.

The purpose of this intermediary letter is to explain the effect of these regulations on providers receiving weekly PIP payments and to furnish instructions for conversion to the bi-weekly cycle required by the regulations.

Background

As you will recall, PIP was first made available in 1968 as a method of interim reimbursement for hospital Part A inpatient services. Hospitals that elected to receive interim reimbursement under this method have been receiving PIP payments on a weekly basis. These payments apply to covered Part A inpatient hospital services furnished beneficiaries by the hospital during the seven day period ending with the date on which each PIP payment is issued. These payments contain an average lag of three days between delivery of services and disbursement of payment for these services.

In January 1973 a moratorium was placed on further conversions to PIP. This restriction was lifted in September 1973 (see IL Part A 73-37) and PIP was made available to other hospitals and to SNF's for Part A inpatient services and to HHA's for both Part A and Part B home health services but the method for computing and disbursing PIP payments to these providers was modified. Providers reimbursed under the modified method receive PIP payments for a two week service period and these payments are issued no earlier than two weeks after the end of the service period to which they apply. PIP payments under the modified method contain an average lag of three weeks between delivery of service and disbursement of PIP payment for these services.

Hospitals receiving weekly PIP payments under the original PIP method were permitted to continue to receive these payments pending publication of final regulations pertaining to PIP.

PIP Regulations

The enclosed regulations require that PIP payments cover a two week service period and be issued no earlier than two weeks after the end of the service period. PIP providers are also required to submit fully completed billing forms for the services for which they are receiving PIP payments.

PIP payments disbursed under the method set forth in IL Part A 73-37 are not affected by these regulations. They fully reflect the requirements in the regulations. The practical effect of the regulations, therefore, is that the PIP service period of providers being reimbursed under the original PIP method must be extended from one to two weeks and intermediary disbursement of PIP payments to these providers must be no earlier than two weeks after the end of the service period to which each payment applies.

When these requirements are fully implemented, PIP payments to all providers will contain an average lag of three weeks between delivery of service and disbursement of payment for the services, as required by the regulations.

Instructions for Implementation of PIP Regulations

If the PIP service period of hospitals presently receiving weekly PIP payments is extended from one to two weeks, concurrent with a delay of two weeks in their intermediary's PIP disbursement schedule, some of the hospitals may experience a serious cash flow problem unless the effect of these conversions on the PIP payments to the hospitals is minimized. Therefore, the effect of these conversions on the PIP payments to these hospitals shall be gradually phased in by May 31, 1976, as explained below.

Weekly PIP payments may not be disbursed after the last week of November 1975. All intermediaries making weekly PIP payments are to convert to a bi-weekly (i.e., every other week) PIP disbursement cycle and the PIP service period of the hospitals to which weekly PIP payments were being made must be extended from one to two weeks no later than the end of November 1975. These conversions may be made earlier if mutually agreeable to the hospital and the intermediary. The effect of these conversions on the amount of the bi-weekly PIP payments to the hospital must be phased-in over the PIP payments disbursed between the conversion date and May 31, 1976. When all the adjusted bi-weekly PIP payments have been made, they will have the effect of moving the PIP disbursement date of the intermediary from the last day of the hospital's two week service period to 14 days after the end of this service period.

Example:

Hospital has been receiving weekly PIP payments of $100,000 and the intermediary has been disbursing these payments on Monday of each week. The hospital and intermediary agree that weekly PIP payments to the hospital

should continue to be made through the disbursement date of Monday, November 24, 1975.

The intermediary's PIP disbursement cycle for this hospital will be converted from weekly to bi-weekly as of November 24, 1975. The first bi-weekly PIP payment to the hospital will be disbursed Monday, December 8, 1975. It will be in the full amount of $200,000 and will cover the service period from November 25, 1975, through December 8, 1975. This change will replace the average 3 day lag with an average lag of 6½ days.

Effective December 9, 1975, the hospital's PIP service period will be extended from seven to 14 days. The amount of the second bi-weekly PIP payment disbursed on December 22, 1975, and all subsequent such payments disbursed through May 24, 1976, must be adjusted, in equal amounts, to gradually build in the remaining days of the average lag. This is accomplished as follows:

Monday Disbursement Date	Amount of PIP Payments to Phase-In Full Lag
November 24, 1975	$ 100,000 (last weekly PIP payment) (covers service period 11/18/75 thru 11/24/75)
December 1, 1975	none
December 8, 1975	$ 200,000 (1st bi-weekly payment) (covers service period 11/25/75 thru 12/8/75)
December 22, 1975	$ 183,333.33 1/
January 5, 1976	$ 183,333.33
January 19, 1976	$ 183,333.33
February 2, 1976	$ 183,333.33
February 16, 1976	$ 183,333.33
March 1, 1976	$ 183,333.33
March 15, 1976	$ 183,333.33
March 29, 1976	$ 183,333.33
April 12, 1976	$ 183,333.34
April 26, 1976	$ 183,333.34
May 10, 1976	$ 183,333.34
May 24, 1976	$ 183,333.34
Total	$2,400,000.00
June 7, 1976	$ 200,000 (covers service period 5/11/76 thru 5/24/76)
June 21, 1976	$ 200,000 (covers service period 5/25/76 thru 6/07/76)

1/ In this example, the total value of the lag is the equivalent of payment for 14 days, in this case $200,000.

Thereafter, that is after May 1976, payments will continue to be bi-weekly but at the full amount of the then current bi-weekly PIP payment.

The above example does not take into consideration possible change in PIP payment amounts resulting from recomputation of the PIP payment following submission of the provider's cost report as required by PRM 2107.5, or the quarterly or other recomputations required by PRM 2407.7. Intermediaries must, when making these recomputations take the steps necessary to insure that full implementation of the PIP regulations payment lag by May 31, 1976, is not prevented by any adjustment to the provider's PIP amount.

Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosures

(4)

Food and Drug Administration

[Docket No. 75N-0213]

FEDERAL-STATE COOPERATIVE PROGRAMS

Codification of Pasteurized Milk Ordinance and Interstate Milk Shippers Program

On May 5, 1975, a notice was published in the FEDERAL REGISTER (40 FR 19513) announcing the availability of a draft of proposed regulations for pasteurized milk in interstate commerce to be issued as Parts 960 through 966 of Subchapter I—Federal-State Cooperative Programs, of Chapter I, Title 21 of the Code of Federal Regulations.

Copies of the draft were distributed to the Federal, State, and industry groups that would be most directly affected if the proposed regulations were adopted, and copies were made available through the office of the Food and Drug Administration Hearing Clerk to any other interested person. A period of 90 days was provided, until August 4, 1975, for submitting comments on the draft to the office of the Hearing Clerk.

During the comment period, the chairman of the National Conference on Interstate Milk Shipments (NCIMS), which consists of State regulatory officials responsible for milk sanitation, met with Food and Drug Administration officials to discuss this matter and submitted a formal resolution in behalf of the NCIMS. The NCIMS opposes publication of the proposed regulations as Federal regulations. In addition, the NCIMS requested a 12-month extension of time to review the draft of the proposed regulations and prepare a response.

Similar requests were also received from the National Association of State Departments of Agriculture, the National Milk Producers Federation, the Milk Industry Foundation, and others.

Based on these discussions and written comments on the subject draft, the Commissioner of Food and Drugs has concluded that he would take no further formal action on the proposed codification of the Pasteurized Milk Ordinance and the Interstate Milk Shippers Program until at least 30 days after the next NCIMS meeting, which is expected to be held early in 1976. At that time and after considering any report that the NCIMS may submit, the Commissioner will determine what course of action is appropriate.

Pertinent views and information may continue to be submitted to the Bureau of Foods, Dairy and Lipid Products Branch (HFF-415), Food and Drug Administration, 200 C St. SW., Washington, DC 20204. All submissions will be considered prior to taking formal action.

Dated: August 25, 1975.

A. M. SCHMIDT,
Commissioner of Food and Drugs.

[FR Doc.75-23119 Filed 8-29-75;8:45 am]

Office of Education

COLLEGE LIBRARY RESOURCES PROGRAM

Notice of Closing Date for Receipt of Applications

Notice is hereby given that pursuant to the authority contained in Part A of Title II of the Higher Education Act of 1965 (20 U.S.C. 1021-1028), applications for basic grants are being accepted from institutions of higher education and other public and private nonprofit library agencies whose primary function is to provide library and information services to institutions of higher education on a formal cooperative basis. Processing of these applications will be subject to the availability of funds.

Applications must be received by the U.S. Office of Education Application Control Center on or before November 17, 1975.

A. *Applications sent by mail.* An application sent by mail should be addressed as follows: U.S. Office of Education, Application Control Center, 400 Maryland Avenue, S.W., Washington, D.C. 20202, Attention: 13:406. An application sent by mail will be considered to be received on time by the Application Control Center if:

(1) The application was sent by registered or certified mail not later than November 12, 1975, as evidenced by the U.S. Postal Service postmark on the wrapper or envelope, or on the original receipt from the U.S. Postal Service; or

(2) The application is received on or before the closing date by either the Department of Health, Education, and Welfare, or the U.S. Office of Education mail room in Washington, D.C. In establishing the date of receipt, the Commissioner will rely on the time-date stamp of such mail rooms or other documentary evidence of receipt maintained by the Department of Health, Education, and Welfare, or the U.S. Office of Education.

B. *Hand delivered applications.* An application to be hand delivered must be taken to the U.S. Office of Education Application Control Center, Room 5673, Regional Office Building Three, 7th and D Streets, S.W., Washington, D.C. Hand delivered applications will be accepted daily between the hours of 8 a.m. and 4 p.m. Washington, D.C. time except Saturdays, Sundays, or Federal holidays. Applications will not be accepted after 4 p.m. on the closing date.

C. *Program information and forms.* Information and application forms will be sent to all institutions which have previously participated in the program. This notice, however, is the official notification of the acceptance of basic grant applications under this program. Other institutions desiring to participate may obtain information and application forms from the Office of Libraries and Learning Resources, Division of Library Programs, Bureau of School Systems, Regional Office Building Three, 7th and D Streets, S.W., Washington, D.C. 20202. Attention: 13.406.

D. *Applicable regulations.* The regulations applicable to this program include the Office of Education General Provisions Regulations (45 CFR Part 100a) and the College Library Resources regulations published in the FEDERAL REGISTER on November 18, 1974 at 40494.

(20 U.S.C. 1021-1028)

Dated: August 26, 1975.

(Catalog of Federal Domestic Assistance Number 13:406; College Library Resources Program)

T. H. BELL,
U.S. Commissioner of Education.

[FR Doc.75-23114 Filed 8-29-75;8:45 am]

Office of the Secretary

FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Periodic Interim Payments

On July 16, 1975, there was published in the FEDERAL REGISTER (40 FR 29315) a final amendment to Subpart D of Regulations No. 5 (20 CFR Part 405), to become effective on August 15, 1975. This amendment requires that periodic interim payments (PIP) be made for no less than a 2 week period of services, with a payment interval of 2 weeks between the end of the period of services to which the payment applies and the date of payment, such interval creating an average lag of 3 weeks between delivery of an ypayment for services. These requirements change the payment interval and service period for those providers which as of the effective date of the regulations were receiving weekly PIP payments with no interval between the end of the weekly period of services and the payment applicable to it. In paragraph (1) of the Preamble to this amendment appeared the statement that intermediaries will be instructed to conform the reimbursement schedules of those providers receiving payment under already existing forms of the PIP mechanism to the revised payment schedule requirements and place all these providers in payment status under the revised schedule no later than September 15, 1975. Although the Department still believes the average 3 week lag is appropriate, strict adherence to the September 15, 1975, implementation date could result in the nonpayment of program reimbursement to over 800 hospitals on the PIP method for approximately four consecutive weeks. This effect is undesirable. It will create extraordinary cash flow problems for these hospitals, especially those located in the large urban centers, making it necessary for the hospitals to borrow equivalent funds from conventional lending sources.

Because it is realized that the time allowed by this amendment to place these

providers on the revised payment schedule will cause a severe fiscal problem for them, the Secretary has determined that additional time should be allowed to permit a phase-in of the revision of payment schedules for those providers receiving payment under pre-existing PIP mechanisms. Accordingly, this notice amends the Preamble to the final PIP regulations to provide for full implementation by May 31, 1976, rather than September 15, 1975. This change can be accomplished without affecting the objectives of the PIP regulations.

For the reasons given above, to alleviate fiscal problems which may occur for certain providers in the implementation of the final regulations, good cause exists to make this notice effective immediately. The date by which providers must be placed on the revised payment schedule is hereby changed to May 31, 1976, from September 15, 1975.

Dated: August 27, 1975.

DAVID MATTHEWS,
Secretary of Health, Education, and Welfare.

[FR Doc.75-23291 Filed 8-29-75;8:45 am]

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. EX75-22; Notice 2]

MOTOR COACH INDUSTRIES, INC.

Petition for Modification of Temporary Exemption From Federal Motor Vehicle Safety Standard

The National Highway Traffic Safety Administration has decided not to grant the petition by General Motors Corporation ("GM") to modify the temporary exemption from Federal Motor Vehicle Safety Standard No. 121, *Air Brake Systems*, granted Motor Coach Industries ("MCI").

Notice of the petition was published on July 7, 1975 (40 FR 28504), and an opportunity afforded for comments.

By an order published March 18, 1975 (40 FR 12307), the Administrator granted MCI and TMC (an allied corporation) "NHTSA Temporary Exemption Nos. 75-6A for MC5-B buses, expiring May 1, 1975, and 75-6B for MC-8 buses, expiring September 1, 1975, from Motor Vehicle Safety Standard No. 121 (paragraph S5.3.1 only.)" GM asked that the scope of the exemption be narrowed and that the MC-8 buses be retrofitted to comply with Standard No. 121. Specifically, GM stated that MCI's problem concerned only the lightly loaded third axle and that "MCI should be required to meet all the requirements of FMVSS 121 including the majority of S5.3.1 except for the lightly loaded third axle which should be exempted only from the 'no-lockup' requirements of S5.3.1." In addition GM argued that "once the problem with the • • • computer on the third axle has been resolved, MCI should be able to retrofit each MC-8 bus manufactured during the exemption period and thus bring each of the buses into complete compliance with FMVSS 121." GM believed that "such a requirement would significantly alleviate the serious competitive disadvantages which non-exempt intercity bus manufacturers and their customers will experience during the exemption period," thus reducing "the substantial manufacturing cost and owner maintenance cost differences between exempt and non-exempt intercity buses." Finally it argued that retrofitting is in the public interest since the vehicles concerned are public conveyances that will be in continuous use over many years.

On July 7, 1975, the Administrator announced that he was considering granting GM's request in part. With respect to modifying the total exemption from S5.3.1, *Stopping distance-trucks and buses*, the NHTSA understood that MCI was, in fact, complying with all portions of S5.3.1 except the portion prohibiting lockup of the third axle. The NHTSA had also learned that MC-8 coaches produced by TMC and one-half of MCI's MC-8 production since the grant of the exemption had conformed with standard No. 121. NHTSA understood also that around July 1, 1975, MCI intended to install an anti-lock wiring harness as part of its production process. The Administrator therefore considered terminating Temporary Exemption No. 75-6B and issuing a new exemption that would expire September 1, 1975, conditioned upon retrofit by January 1, 1976, of all vehicles produced under the new exemption. The proposed effective date was the date of issuance of the new exemption.

Comments were received only from GM and MCI. GM again reiterated its original request that MCI be required to retrofit all non-conforming buses produced under the exemption. MCI advises that "they are phasing the anti-skid on all MC-8 coaches on the start of the assembly line as per June 25, 1975 with delivery to the customer scheduled for August 5, 1975." It therefore appears that MCI has acted in good faith to comply with Standard No. 121 in advance of the expiration of Exemption No. 75-6B, and that all its production will conform not later than August 5, 1975. The NHTSA therefore has determined that events have made unnecessary or impracticable the action proposed on July 7, 1975, and GM's petition is therefore denied.

(Sec. 3, Pub. L. 92-548; 86 Stat. 1159 (15 U.S.C. 1417); delegation of authority at 49 CFR 1.51.)

Issued on August 27, 1975.

ROBERT L. CARTER,
Acting Administrator.

[FR Doc.75-23125 Filed 8-29-75;8:45 am]

CIVIL AERONAUTICS BOARD

[Docket 26510]

DOMESTIC NIGHT COACH FARE INVESTIGATION

Notice of Hearing

Notice is hereby given, pursuant to the provisions of the Federal Aviation Act of 1958, as amended, that a hearing in the above-entitled proceeding will be held on September 29, 1975, at 10 a.m. (local time), in Room 726, Universal Building, 1825 Connecticut Avenue, N.W., Washington, D.C., before the undersigned administrative law judge.

For information concerning the issues involved and other details in this proceeding, interested persons are referred to the prehearing conference report served on March 21, 1975, and other documents which are in the docket of this proceeding on file in the Docket Section of the Civil Aeronautics Board.

Dated at Washington, D.C., August 26, 1975.

[SEAL] GREER M. MURPHY,
Administrative Law Judge.

[FR Doc.75-23175 Filed 8-29-75;8:45 am]

ENVIRONMENTAL PROTECTION AGENCY

[OPP-50028; FRL 423-1]

HERCULITE PROTECTIVE FABRICS CORP.

Issuance of Experimental Use Permit

Pursuant to section 5 of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), as amended (86 Stat. 973; 7 U.S.C. 136), an experimental use permit has been issued to Herculite Protective Fabrics Corporation, New York, N.Y. 10010. Such permit is in accordance with, and subject to, the provisions of 40 CFR Part 172; Part 172 was published in the FEDERAL REGISTER on April 30, 1975 (40 FR 18780), and defines EPA procedures with respect to the use of pesticides for experimental purposes.

This experimental use permit (No. 8730-EUP-2) allows the use of a total of 5.09 pounds of chlorpyrifos on cockroaches and waterbugs in residential, commercial, industrial, and institutional buildings. The program is authorized only in the States of California, Connecticut, Florida, Georgia, Indiana, Louisiana, Maryland, Michigan, New York, Oklahoma, Oregon, Tennessee, Texas, and Wisconsin. The experimental use permit is effective from August 3, 1975, to August 3, 1976.

Interested parties wishing to review the experimental use permit are referred to Room E-315, Registration Division (WH-567), Office of Pesticide Programs, EPA, 401 M St., S.W., Washington, D.C. 20460. It is suggested that such interested persons call 202/755-4851 before visiting the EPA Headquarters Office, so that the appropriate permit may be made conveniently available for review purposes. These files will be available for inspection from 8:30 a.m. to 4 p.m. Monday through Friday.

Dated: August 26, 1975.

EDWIN L. JOHNSON,
Deputy Assistant Administrator for Pesticide Programs.

[FR Doc.75-23073 Filed 8-29-75;8:45 am]

d. On final approach at 170 KIAS, lower gear and landing flaps and reduce speed to 165 KIAS. This will result in a stick force of approximately 12 lbs. pull. Maintain 165 KIAS on final approach. The approach at 165 kts. and 30° flaps will result in an attitude with the nose lower than normal. All other check list procedures are unchanged.

e. At approximately 100 ft. above ground level slowly reduce the power to idle. The airplane should be flown onto the runway with a slight flare to assure that the nose wheel will not touch first. Plan to touch down at approximately 150 KIAS. Apply maximum reverse thrust and brake as necessary. Stick force during flare and touchdown will increase to about 30 lbs. Care should be taken not to flare high, thereby using more runaway than necessary.

f. Due to the higher touchdown speed, the landing distances will be increased. The required runway length has not been determined, but landings have been made in less than 7,000 feet of runway by using maximum reverse thrust and light braking.

B. Limitations—Page 1-9. Under Stall Warning/Stall Barrier System add:

INTENTIONAL STALLS ARE PROHIBITED

C. To prevent the stall barrier stick pusher from remaining energized after actuation, due to portions of the hydraulic filters becoming lodged in the stall barrier valves, accomplish the following: Replace the stall barrier hydraulic in-line filters and inspect and leak check the stall barrier valves and cylinder if the replaced filters are determined to be not intact upon removal, according to Grumman American Service Change 199, or in an equivalent manner approved by the Chief, Engineering and Manufacturing Branch, Southern Region, Atlanta, Georgia.

This amendment becomes effective July 18, 1975.

This amendment is made under the authority of Sections 313(a), 601, and 603, of the Federal Aviation Act of 1958 (49 U.S.C. 1354(a), 1421, and 1423) and of Section 6(c) of the Department of Transportation Act (49 U.S.C. 1655(c)).

Issued in East Point, Georgia, on July 8, 1975.

P. M. SWATEK,
Director, Southern Region.

[FR Doc.75-18351 Filed 7-15-75;8:45 am]

[Docket No. 13995; Amdt. 39-2265]

PART 39—AIRWORTHINESS DIRECTIVES

Dowty Rotol Type (c) R212/4-30-4/22 Propellers

A proposal to amend Part 39 of the Federal Aviation Regulations to include an airworthiness directive requiring inspections of Dowty Rotol Type (c) R212/4-30-4.22 propellers for cracks and their replacement if necessary was published in the FEDERAL REGISTER (39 FR 33233).

Interested persons have been afforded an opportunity to participate in the making of the amendment. No objections were received.

This amendment is made under the authority of sections 313(a), 601, and 603 of the Federal Aviation Act of 1958 (49 U.S.C. 1354(a), 1421, and 1123) and of section 6(c) of the Department of Transportation Act (49 U.S.C. 1655(c)).

In consideration of the foregoing, and pursuant to the authority delegated to me by the Administrator (14 CFR § 11.89), § 39.13 of Part 39 of the Federal Aviation Regulations is amended by adding the following new airworthiness directive:

DOWTY ROTOL. Applies to Dowty Rotol Type (c) R212/4-30-4.22 propellers incorporating hub and driving center assemblies, P/N's 601022204, 601022211, 601022105, and RA 6488.1, that have not been modified in accordance with Dowty Rotol Modification Nos. (c) VP2388 (SB 61-604) or (c) VP2779 (SB 61-767). These propellers are installed on, but not necessarily limited to, Hawker Siddeley Model H.S. 748 Series 2A airplanes.

Compliance is required as indicated.

To detect cracking of the propeller hub front wall/snout radius areas between the eyebolt guides, accomplish the following:

(a) Inspect the propeller hubs in accordance with Paragraph 2.A. of Dowty Rotol Service Bulletin No. 61-828, dated September 10, 1973, or an FAA-approved equivalent as follows:

(1) For those operators required to perform propeller overhauls, inspect at the next propeller overhaul and at each propeller overhaul thereafter.

(2) For all other operators, inspect within the next 4000 hours' time in service after the effective date of this AD, and thereafter inspect at intervals not to exceed 4000 hours' time in service since last inspection.

(b) Inspect those propeller hubs that have accumulated more than 10,000 hours' time in service on the effective date of this AD in accordance with Paragraph 2.B. of Dowty Rotol Service Bulletin No. 61-828, dated September 10, 1973, or an FAA-approved equivalent, unless already accomplished, as follows:

(1) For those propeller hubs that have never been inspected or that have accumulated more than 1400 hours' time in service since last inspected in accordance with Paragraph 2.A. or 2.B. of Dowty Rotol Service Bulletin No. 61-828, dated September 10, 1973, inspect within the next 600 hours time in service.

(2) For those propeller hubs that have accumulated not more than 1400 hours' time in service since last inspected in accordance with Paragraph 2.A. or 2.B. of Dowty Rotol Service Bulletin No. 61-828, dated September 10, 1973, inspect prior to the accumulation of 2000 hours' time in service since last inspected.

(c) If a cracked hub is found during an inspection required by this AD, accomplish the following:

(1) Before further flight, replace the cracked hub with a serviceable part of the same part number or a part number approved for installation on the propeller.

(2) Inspect all the operator's propeller hubs covered by this AD in accordance with Paragraph 2.B. of Dowty Rotol Service Bulletin No. 61-828, dated September 10, 1973 or an FAA-approved equivalent as follows:

(i) For those propeller hubs that have accumulated more than 1400 hours' time in service since last inspected in accordance with paragraph (a) or (b) of this AD or that have never been inspected and have accumulated over 1400 hours' time in service, inspect within the next 600 hours' time in at intervals not to exceed 2,000 hours' time service; and, thereafter, continue to inspect in service since last inspection.

(ii) For those propeller hubs that have acumulated not more than 1400 hours' time in service since new or since last inspected in accordance with paragraph (a) or (b) of this AD, inspect prior to the accumulation of 2000 hours' time in service, since last inspected or since new, as applicable, and thereafter, continue to inspect at intervals not to exceed 2000 hours' time in service since last inspection.

(d) The inspections required by paragraphs (a), (b), and (c) of this AD may be discontinued upon the incorporation of Dowty Rotol Modification Nos. (c) VP 2388(SB61-604) or (c) VP2779(SB61-767) or FAA-approved equivalent modifications.

(e) Upon request of an operator, an FAA maintenance inspector subject to prior approval of the Chief, Aircraft Certification Staff, Europe, Africa, and Middle East Region, may adjust the repetitive inspection intervals specified in this AD to permit compliance at an established inspection period of the operator, if the request contains substantiating data to justify the adjustment.

This amendment becomes effective August 15, 1975.

Issued in Washington, D.C. on July 9, 1975.

J. A. FERRARESE,
Acting Director,
Flight Standards Service.

[FR Doc.75-18352 Filed 7-15-75;8:45 am]

Title 16—Commercial Practices

CHAPTER II—CONSUMER PRODUCT SAFETY COMMISSION

PART 1031—EMPLOYEE MEMBERSHIP AND PARTICIPATION IN VOLUNTARY STANDARDS ORGANIZATIONS

Promulgation of Policy; Correction

In FR Doc. 75-16103 appearing at page 26023 in the issue of June 20, 1975, the first sentence of paragraph 14 in the third column on page 26024 is corrected to read "A comment suggests that a CPSC employee who participates in the development of a voluntary standard should be prohibited from later participating in an official CPSC capacity in the evaluation of the standard."

Dated: July 9, 1975.

SADYE E. DUNN,
Secretary, Consumer Product
Safety Commission.

[FR Doc.75-18399 Filed 7-15-75;8:45 am]

Title 20—Employees' Benefits

CHAPTER III—SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

[Reg. No. 5, further amended]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Periodic Interim Payments to Title XVIII Providers

On January 16, 1974, there was published in the FEDERAL REGISTER (39 FR 2011) a Notice of Proposed Rule Making with a proposed amendment to Subpart D of Regulations No. 5 (20 CFR Part 405), regarding Periodic Interim Payments (PIP) to title XVIII providers. Interested parties were given 30 days within which to submit written comments or suggestions on the proposed amendment. Comments and suggestions received in regard to this Notice of Proposed Rule Making, responses thereto, and changes in the proposed regulation are summarized below.

1. Many commented on the requirement that Periodic Interim Payments be made for no less than a 2-week period of services, with a payment interval of 2 weeks between the end of the period of services to which the payment applies and the date of payment, such interval creating an average lag of 3 weeks between delivery of and payment for services. These arguments stated that such a payment schedule would severely hinder the cash flow of providers and their ability to meet working capital needs since a major share of providers' costs are associated with personnel payrolls and payments to vendors that are typically paid on at least a weekly or biweekly basis, and if such a proposal is retained in the final regulations, many providers will be forced to borrow additional working capital from lending institutions, thereby incurring interest costs that will increase their overall cost of furnishing health care, a significant portion of which will be borne by Medicare. However, careful consideration of the introduction of an average 3-week payment lag into the PIP method demonstrated that such a lag compares favorably with the average lag in payment experienced by providers reimbursed under regular interim payment procedures. Therefore, suggestions to abandon the proposed amendment introducing a 3-week payment lag into the PIP method were not adopted. In addition, intermediaries will be instructed to conform the reimbursement schedules of those providers receiving payment under already existing forms of the PIP mechanism to the revised payment schedule requirements and place all these providers in payment status under the revised schedule no later than September 15, 1975. The time period for intermediaries to adjust and implement the revised schedule is necessary to effect uniformity with respect to the interval of payment as soon as is administratively feasible.

2. Others who commented recommended that the practice of completing bills in abbreviated form be retained because the detailed billing requirement would increase the provider's administrative costs and, in turn, Medicare's costs. During the period prior to September 1973, the program did allow skeleton billings under PIP, with the hospital's regular bill attached for reference. In practice, it was found the procedure created extensive claims verification problems for intermediaries. A disproportionately high percentage of the claims had to be returned to providers for additional information because of discrepancies between the statements on the skeleton bill and the charge items on the provider's regular bill form. This resulted in delays in cost settlements, multiple handling of claims, and unnecessarily added communication between providers and intermediaries. For these reasons, all providers converting to the PIP method after September 1973 have been required to use detailed billing, although providers which had been under PIP prior to that time have continued to use the abbreviated billing procedures. Because the abbreviated billing procedure has created the administrative difficulties described above, the latter group of providers, those on PIP prior to September 1, 1973, also will be required to convert from the abbreviated billing procedures they currently use to the detailed billing practices followed by all other providers under PIP.

3. The proposed amendment permitted a provider to convert to PIP if the provider agreed to the intermediary's recovery of the provider's outstanding current financing payment by offset against the provider's periodic interim payments at a rate that would have effectuated full recovery by May 29, 1974. Since the date of May 29, 1974, has passed, this has been deleted from the final regulation. The proposed amendment also permitted a provider to elect to be reimbursed under the PIP method if, in addition to meeting other criteria, the provider had repaid or agreed to repay its outstanding current financing payment in full before the effective date of its requested conversion from a regular interim payment method to the PIP method. This provision has been retained. However, to clarify in the regulation the requirement clearly set forth in the Preamble to the proposed regulation, the final regulation states that a provider requesting to convert to PIP must repay, rather than merely agree to repay, its outstanding current financing payment in full before the effective date of its requested conversion from a regular interim method to the PIP method.

4. Various editorial changes have also been made in the interest of clarity.

The amendment is adopted as proposed except for the changes mentioned above, and is set forth below.

(Secs. 1102, 1814(b), 1815, 1833(a), 1871 of the Social Security Act, 49 Stat. 647, as amended, 79 Stat. 296, 297, as amended, 79 Stat. 302, as amended, 79 Stat. 331; 42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1395hh)

Effective date: August 15, 1975.

(Catalog of Federal Domestic Assistance Program No. 13.800, Health Insurance for the Aged and Disabled—Hospital Insurance, and 13.801, Health Insurance for the Aged and Disabled—Supplementary Medical Insurance.)

Dated: May 12, 1975.

J. B. CARDWELL,
Commissioner of Social Security.

Approved: July 11, 1975.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

Regulations No. 5 of the Social Security Administration, as amended (20 CFR Part 405), are further amended as set forth below:

Section 405.454 is amended by adding a new paragraph (j) to read as follows:

§ 405.454 Payments to providers.

* * * * *

(j) *Periodic interim payment method of reimbursement.* In addition to the regular methods of interim payment on individual provider billings for covered services, the periodic interim payment (PIP) method is available for Part A hospital and skilled nursing facility inpatient services and for both Part A and Part B home health agency services.

(1) Any participating provider that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the intermediary finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least $25,000 a year computed under the PIP formula or, in the case of a home health agency, either (A) its estimated total Medicare reimbursement for Part A and Part B services is at least $25,000 a year computed under the PIP formula or (B) its estimated Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable costs,

(ii) The provider has filed at least one completed Medicare cost report accepted by the intermediary as providing an accurate basis for computation of program payment (except in the case of a provider requesting reimbursement under the PIP method upon first entering the program),

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis, and

(iv) The provider has repaid or agrees to repay any outstanding current financing payment in full, such payment to be made before the effective date of its requested conversion from a regular interim payment method to the PIP method.

(2) No conversion to the PIP method may be made with respect to any provider until after that provider has repaid in full its outstanding current financing payment.

(3) The intermediary's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the intermediary's best judgment as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The intermediary may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under the PIP method shows that proper payment cannot be made under this method.

(4) Payment will be made biweekly under the PIP method unless the provider requests a longer fixed interval (not to exceed 1 month) between payments. The payment amount will be computed by the intermediary to approximate, on the average, the cost of covered inpatient or home health services rendered by the provider during the period for which the payment is to be made, and each pay-

ment will be made 2 weeks after the end of such period of services. Upon request, the intermediary will, if feasible, compute the provider's payments to recognize significant seasonal variation in Medicare utilization of services on a quarterly basis starting with the beginning of the provider's reporting year.

(5) A provider's periodic interim payment amount may be appropriately adjusted at any time if the provider presents or the intermediary otherwise obtains evidence relating to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the intermediary will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The intermediary may make a retroactive lump sum interim payment to a provider, based upon an increase in its periodic interim payment amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of intermediary monitoring of provider costs and utilization is to assure payments approximating, as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services is the timely submittal to the intermediary of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

[FR Doc.75-18444 Filed 7-15-75;8:45 am]

Title 21—Food and Drugs

CHAPTER I—FOOD AND DRUG ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

[Docket No. 75N-0105]

PART 2—ADMINISTRATIVE PRACTICES AND PROCEDURES

Public Hearing Before a Public Advisory Committee; Standing Advisory Committees

Elsewhere in this issue of the FEDERAL REGISTER, the Commissioner of Food and Drugs is announcing the establishment of the Dermatology Advisory Committee by the Secretary of Health, Education, and Welfare.

Therefore, pursuant to provisions of the Federal Food, Drug, and Cosmetic Act (sec. 701(a), 52 Stat. 1055 (21 U.S.C. 371)), and under authority delegated to the Commissioner (21 CFR 2.120), § 2.340 is amended by adding a new paragraph (c) (20) to reflect the addition of the Dermatology Advisory Committee. As amended, § 2.340(c) (20) reads as follows:

§ 2.340 List of standing advisory committees.

* * * * *

(c) * * *

(20) *Dermatology Advisory Committee.* (i) Date established: June 20, 1975.

(ii) Function: Reviews and evaluates available data concerning safety and effectiveness of marketed and investigational prescription drugs for use in the practice of dermatology.

* * * * *

Effective date. This regulation shall become effective on July 28, 1975.

(Sec. 701(a), 52 Stat. 1055 (21 U.S.C. 371))

Dated July 10, 1975.

SAM D. FINE,
Associate Commissioner for Compliance.

[FR Doc 75-18389 Filed 7-15-75;8:45 am]

[Docket No. 75C-0037]

PART 8—COLOR ADDITIVES

Termination of Provisional Listing of Powdered Silk

The Commissioner of Food and Drugs is terminating the postponement of the closing date of the provisional listing for the use of powdered silk as a color additive in cosmetics effective October 14, 1975. The order is providing 90 days to allow for an orderly change in any cosmetic formulations that utilize powdered silk as a color additive.

Provisional listing for powdered silk had been made so that the evaluation of a color additive petition (CAP 8C0[illegible]) for powdered silk in cosmetics could be completed. However, the petitioner, H. H. Laboratories, Inc., a subsidiary of Helena Rubenstein, Inc., Northern Blvd., Greenvale, L.I., N.Y. 10017, has requested withdrawal of the petition without prejudice to a future filing. In order to continue provisional listing of the substance, it is necessary for some interested person to submit a color additive petition or progress reports of ongoing scientific studies in support of the continuation. The Commissioner is unaware of any other interest in the listing of powdered silk as a color additive. Accordingly, he concludes that the closing date for the provisional listing of powdered silk for use in cosmetics should not be postponed any longer.

Therefore, pursuant to transitional provisions of the Color Additive Amendments of 1960 to the Federal Food, Drug, and Cosmetic Act (sec. 203(a) (2), (d) (2), Title II, Pub. L. 86-618; 74 Stat. 404 (21 U.S.C. 376, note)), and under authority delegated to the Commissioner (21 CFR 2.120), Part 8 is amended in Subpart—Provisional Regulations by deleting "Silk, powdered" from the list of color additives in the table in § 8.501 (g).

Notice and public procedure are not necessary prerequisites to the promulgation of this order because section 203(d) (2) of Pub. L. 86-618 so provides.

Effective date. This order shall become effective October 14, 1975. Any use of powered hydrolyzed silk in cosmetics as a color additive after that date will result in the cosmetic being considered adulterated under section 601 of the act and subject to regulatory action.

(Sec. 203(a) (2), (d) (2), Title II, Pub. L. 86-618; 74 Stat. 404 (21 U.S.C. 376, note).)

Dated: July 10, 1975.

SAM D. FINE,
Associate Commissioner for Compliance.

[FR Doc.75-18387 Filed 7-15-75;8:45 am]

Title 23—Highways

CHAPTER I—FEDERAL HIGHWAY ADMINISTRATION, DEPARTMENT OF TRANSPORTATION

PART 160—STATE FISCAL PROCEDURES AND REPORTS

Transfer of Highway Safety Funds

Chapter I of Title 23, Code of Federal Regulations, is amended by adding a new Subpart B—Transfer of Highway Safety Funds—to Part 160—State Fiscal Procedures and Reports—as set forth below. The new Subpart B codifies policies and procedures pertaining to the transfer of funds among highway safety programs under 23 U.S.C. 104(g), as amended by section 227 of the Highway Safety Act of 1973.

This amendment to Title 23, Code of Federal Regulations, was prepared under the authority of 23 U.S.C. §§ 104(g) and 315, and the delegation of authority by the Secretary of Transportation at 49 CFR 1.48.

Subpart B—Transfer of Highway Safety Funds

Sec.
160.201 Purpose.
160.202 Limitation on Transfer of Funds.
160.203 Requirements and Conditions.
160.204 Submission of Request.

AUTHORITY: 23 U.S.C. §§ 104, 315; 49 CFR 1.48.

§ 160.201 Purpose.

The purpose of this subpart is to prescribe the procedure for transfer of funds among highway safety programs under 23 U.S.C. 104(g), as amended by section 227 of the Highway Safety Act of 1973.

§ 160.202 Limitation on Transfer of Funds.

Not more than 30 percent of the amount apportioned to each State for a fiscal year under sections 144 (Special Bridge Replacement Program); 152 (Projects for High-Hazard Locations), and 153 (Program for the Elimination of Roadside Obstacles) of Title 23, United States Code, or Section 203(d) (Rail-Highway Crossings) of the Highway Safety Act of 1973, may be transferred from the apportionment under one section to the apportionment under any other of such sections in accordance with the requirements and conditions of § 160.203 of this subpart.

§ 160.203 Requirements and Conditions.

(a) For the purposes of 23 U.S.C. 104 (g), the terms "apportioned" and "apportionment" include the terms "allocate" and "allocation." Funds allocated under 23 U.S.C. 144 may be transferred to apportionments under 23 U.S.C. 152

(1) For exposure times of less than one-half second, the means provided may allow completion of the exposure in progress but shall enable the operator to prevent additional exposures.

* * * * *

Interested persons may, on or before February 15, 1974, file with the Hearing Clerk, Food and Drug Administration, Room 6-86, 5600 Fishers Lane, Rockville, MD 20852, written comments (preferably in quintuplicate) regarding this proposal. Comments may be accompanied by a memorandum or brief in support thereof. Received comments may be seen in the above office during working hours, Monday through Friday.

Dated: January 11, 1974.

WILLIAM F. RANDOLPH,
Acting Associate Commissioner for Compliance.

[FR Doc.74-1460 Filed 1-16-74;8:45 am]

Social Security Administration

[20 CFR Part 405]

[Reg. 5]

FEDERAL HEALTH INSURANCE FOR AGED AND DISABLED

Provider Costs and Services by Hospital-Based Physicians; Periodic Interim Payments

Notice is hereby given, pursuant to the Administrative Procedure Act (5 U.S.C. 553) that the regulation set forth in tentative form below is proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare. The proposed regulation reflects current policies of the Social Security Administration which authorize fiscal intermediaries to make periodic interim payments (PIP) to eligible providers for hospital and skilled nursing facility inpatient services and for home health agency services to medicare beneficiaries in lieu of reimbursement under the regular methods of interim payment on individual provider billings. The proposed regulation reflects recently issued interim policy, for use pending publication of final regulations, that, effective September 1, 1973, (1) lifts a moratorium imposed on January 29, 1973, on approvals of hospital requests for reimbursement under the PIP method, (2) extends the availability of the PIP method to qualified skilled nursing facilities for inpatient services and to qualified home health agencies for both Part A and Part B services, (3) permits a provider to convert to the PIP method only after it has repaid any outstanding current financing payment in full, unless it agrees to the intermediary's recovery of the current financing amount outstanding on the effective date of the conversion by offset against the provider's periodic interim payments at a rate that will effectuate full recovery by May 29, 1974, (4) requires that payment to a provider under the PIP method be made for no less than a 2-week period of services, not more often than biweekly, and 2 weeks after the period to which it pertains, (5) requires all providers to complete billings in detail (rather than in an abbreviated form, as previously provided for) under the PIP method as under regular interim payment procedures, and (6) provides for the termination of PIP reimbursement to a provider under appropriate circumstances. The proposed amendment will be effective upon publication of final regulations in the FEDERAL REGISTER. Provisions (4) and (5) above, which would affect hospitals being reimbursed under the PIP method before September 1, 1973, would be phased in after the date of publication of final regulations. Implementing instructions would provide that payment periods of less than 2 weeks be extended to 2 weeks on publication of the regulation in final form, and that the interval between the date of payment and the period to which it applies be increased to 2 weeks in steps by adding 1 week to the interval for payment periods ending in the calendar quarter beginning January 1, 1974, and a second week for payment periods ending thereafter. Hospital conversions from the abbreviated billing procedures they currently use under the PIP method to detailed billing will be effected as soon as administratively feasible following publication of final regulations in the FEDERAL REGISTER.

Prior to the final adoption of the proposed amendment to the regulations, consideration will be given to any data, views, or arguments pertaining thereto which are submitted in writing in triplicate to the Commissioner of Social Security, Department of Health, Education, and Welfare Building, Fourth and Independence Avenue SW., Washington, D.C. 20201, on or before February 15, 1974.

Copies of all comments received in response to this notice will be available for public inspection during regular business hours at the Washington Inquiries Section, Office of Public Affairs, Social Security Administration, Department of Health, Education, and Welfare, North Building, Room 4146, 330 Independence Avenue SW., Washington, D.C. 20201.

(Secs. 1102, 1815, and 1871, 49 Stat. 647, as amended, 79 Stat. 297, and 79 Stat. 331; (42 U.S.C. 1302, 1395g, and 1395hh))

(Catalog of Federal Domestic Assistance Program No. 13.800, Health Insurance for the Aged—Hospital Insurance.)

Dated: November 20, 1973.

JAMES B. CALDWELL,
Commissioner of Social Security.

Approved: January 7, 1974.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

Regulations No. 5 of the Social Security Administration, as amended (20 CFR Part 405), are further amended as set forth below:

Section 405.454 is amended by adding a new paragraph (j) to read as follows:

§ 405.454 Payments to providers.

* * * * *

(j) *Periodic interim payment method of reimbursement.* In addition to the regular methods of interim payment on individual provider billings for covered services, the periodic interim payment (PIP) method is available for hospital and skilled nursing facility inpatient services and for both Part A and Part B home health agency services.

(1) Any participating provider that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the intermediary finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least $25,000 a year computed under the PIP formula or, in the case of a home health agency, either (A) its estimated total Medicare reimbursement for Part A and Part B services is at least $25,000 a year computed under the PIP formula or (B) its estimated Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable costs,

(ii) The provider has filed at least one acceptable completed Medicare cost report (except in the case of a provider requesting reimbursement under the PIP method upon first entering the program),

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis, and

(iv) The provider has repaid or agrees to repay any outstanding current financing payment in full before the effective date of its requested conversion from a regular interim payment method to the PIP method, unless the provider agrees to the intermediary's recovery of the current financing amount outstanding on the effective date of the conversion by offset against the provider's periodic interim payments at a rate that will effectuate full recovery by May 29, 1974.

(2) The intermediary's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the intermediary's best judgment as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The intermediary may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under the PIP method shows that proper payment cannot be made under this method.

(3) Payment will be made biweekly under the PIP method unless the provider requests a longer fixed interval (not to exceed 1 month) between payments. The payment amount will be computed by the intermediary to approximate, on the average, the cost of covered inpatient or home health services rendered by the provider during the period for which the payment is to be made, and each pay-

ment will be made 2 weeks after the end of such period of services. Upon request, the intermediary will, if feasible, compute the provider's payments to recognize significant seasonal variation in Medicare utilization of services on a quarterly basis starting with the beginning of the provider's reporting year.

(4) A provider's periodic interim payment amount may be appropriately adjusted at any time if the provider presents or the intermediary otherwise obtains evidence relating to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the intermediary will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The intermediary may make a retroactive lump sum interm payment to a provider, based upon an increase in its periodic interim payment amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of intermediary monitoring of provider costs and utilization is to assure payments approximating, as closely as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services is the time'y submittal to the intermediary of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

[FR Doc.74-1193 Filed 1-15-74;8:45 am]

[20 CFR Part 416]

[Reg. 16]

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Underpayments and Overpayments

Notice is hereby given, pursuant to the Administrative Procedure Act (5 U.S.C. 553), that the amendments to the Regulations set forth in tentative form are proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare. The proposed amendments add several sections to proposed new Subpart E of new Part 416 (20 CFR) relating to underpayments and overpayments under the new supplemental security income program (title XVI of the Social Security Act, as amended by section 301 of the Social Security Amendments of 1972 (Pub. L. 92-603), enacted October 30, 1972). The new program is effective January 1, 1974.

Under the proposed regulations provisions are made for the waiver of recovery of overpayments if the overpaid person was without fault in causing the overpayment. If such is the case, waiver would be appropriate if repayment would be against equity and good conscience or would defeat the purpose of the program, or (because of the small amount involved) impede efficient or effective administration of the program. With the exception of the latter provision, these rules generally parallel the policy and procedure of the social security program authorized by title II of the Social Security Act.

The proposed rules regarding underpayments are more restrictive than these of the title II social security program because the supplemental security income program is based on need. Should an underpayment occur, payment of such after discovery may not be in an amount larger than the correct amount of benefits that should have been paid during the 12 months before the month of discovery minus any sums that were actually paid. Should an individual die before receiving payment, the unpaid sum would be paid to his surviving spouse, provided she was also eligible for benefits and was living with him at the time of death. If there is no surviving eligible spouse, no one can receive the underpayment.

The rules set forth in the proposed regulations will be applied by the Social Security Administration in order to administer the Supplemental Security Income program during the period from January 1, 1974, when the new program becomes effective, until final regulations are adopted.

Prior to the final adoption of the proposed amendments to the regulations, consideration will be given to any data, views, or arguments pertaining thereto which are submitted in writing in triplicate to the Commissioner of Social Security, Department of Health, Education, and Welfare Building, Fourth and Independence Avenue SW., Washington, D.C. 20201, on or before February 15, 1974.

Copies of all comments received in response to this notice will be available for public inspection during regular business hours at the Washington Inquiries Section, Office of Public Affairs, Social Security Administration, Department of Health, Education, and Welfare, North Building, Room 4146, 330 Independence Avenue SW., Washington, D.C. 20201.

(Secs. 1102, 1631(b), 49 Stat. 647, as amended, 86 Stat. 1476 (42 U.S.C. 1302, 1383))

(Catalog of Federal Domestic Assistance Program No. 13.807, Supplemental Security Income Program.)

Dated: December 28, 1973.

ARTHUR E. HESS,
Acting Commissioner of Social Security.

Approved: January 9, 1974.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

It is proposed to amend 20 CFR Part 416 by adding new §§ 416.533–416.572 to proposed Subpart E to read as follows:

Subpart E—Payments, Underpayments, Overpayments

Sec.
416.533 Transfer or assignment of benefits.
416.535 Underpayments and overpayments—general.
416.536 Underpayments—defined.
416.537 Overpayments—defined.
416.538 Amount of underpayment or overpayment.
416.542 Underpayments—to whom payable.
416.543 Underpayments—used to reduce overpayments.
416.550 Waiver of adjustment or recovery of overpayment—when applicable.
416.551 Waiver of adjustment or recovery of overpayment—effect of.
416.552 Waiver of adjustment or recovery of overpayment—without fault
416.553 Waiver of adjustment or recovery of overpayment—defeat the purpose of title XVI.
416.554 Waiver of adjustment or recovery of overpayment—against equity and good conscience.
416.555 Waiver of adjustment or recovery of overpayment—impede administration.
416.560 Recovery—refund.
416.570 Adjustment—general rule.
416.572 Adjustment—installment basis.

Subpart E—Payments, Underpayments, Overpayments

§ 416.533 Transfer or assignment of benefits.

The Administration shall not certify payment of supplemental security income benefits to a transferee or assignee of a person eligible for such benefits under the Act. The Administration shall not certify payment of supplemental security income benefits to any person claiming such payment by virtue of an execution, levy, attachment, garnishment, or other legal process or by virtue of any bankruptcy or insolvency proceeding against or affecting the person eligible for benefits under the Act.

§ 416.535 Underpayments and overpayments—general.

Pursuant to section 1631(b) of the Act, an underpayment adjustment as set forth in §§ 416.542–416.543 is made when a recipient received less than the correct amount of supplemental security income benefits; and an overpayment adjustment as set forth in §§ 416.570–416.572 is made when a recipient received more than the correct amount of supplemental security income benefits.

§ 416.536 Underpayments—defined.

An underpayment can occur only with respect to a period for which a recipient filed application (where required) for benefits and met all conditions of eligibility therefor. An underpayment includes:

(a) Nonpayment, where payment for a quarter (or month, where applicable) was due but was not made, and

(b) Payment of less than the amount due for any quarter (or month, where applicable).

§ 416.537 Overpayments—defined.

(a) *Overpayments.* As used in this subpart, the term "overpayment" means a payment where no amount is payable under Title XVI of the Act, or a payment in excess of the amount due under Title XVI of the Act.

(b) *Actions which are not overpayments—(1) Presumptive disability.* Any payment made for any month, but not exceeding payment for 3 months, based on presumptive disability, is not an over-

Plaintiffs' Exhibit 2

[INTERMEDIARY LETTER 73-37 DATED FEBRUARY, 1973
(CONTAINED IN PARAGRAPH 26,752 OF THE
CCH MEDICARE AND MEDICAID GUIDE)]

Physician Reimbursement.—The attached Bureau of Health Insurance (BHI) Part B Intermediary Letter 73-14 [¶ 26,674] provides instructions to implement Economic Stabilization Policies in calculating Medicare fee screens for fiscal year 1974.

Under Phase IV, increases in fee screens are limited to 2½ percent for fiscal year 1974. Where Medicare fee screens are used in computing title XIX payments to individual practitioners, the State agency shall use the attached instructions. For States using other methods, the title XVIII fee screen is to be used in determining the upper limits for payment in accordance with 45 CFR 250.30(b)(3)(i)(c) and Section 224 of P. L. 92-603.

¶ 26,748 PENNSYLVANIA—COVERAGE OF ELECTIVE ABORTIONS UNDER MEDICAID

Opinion of the Attorney General, Pennsylvania, Opinion No. 55, Aug. 6, 1973.

Pennsylvania—Coverage of elective abortions under Medicaid.—Insofar as the Pennsylvania Medicaid regulations (*D. P. W. Manual*, Sec. 9421.521(e)) restrict the right of indigent women to obtain elective abortions when such restriction is not required by Federal or State statute, these regulations may be revised in accordance with standards set by the U. S. Supreme Court in *Roe v. Wade* (410 U. S. 113) and in *Doe v. Bolton* (410 U. S. 179); however, this opinion does not address the question of whether such revision would be required. The U. S. Supreme Court's standards, as set by these decisions, provide that: (1) a woman's right of privacy includes the right to decide, in consultation with her physician and without State interference, to have an abortion during the first trimester of pregnancy; (2) during the second trimester, the State may impose limitations that are designed to protect the woman's health; and (3) during the third trimester or after viability of the fetus, the State may prohibit abortion except when medical opinion indicates that bringing the pregnancy to term would endanger the life or health of the woman. *Back references:* ¶ 14,511, 15,632.

[¶ 26,749] [The proposed regulations implementing the 1972 Amendments concerning elimination of the three-year time limit on Part B enrollment and equitable relief where enrollment rights have been prejudiced by government error, previously reported at this paragraph, have been adopted and are now reported in place at ¶ 18,581 and 18,617.]

[¶ 26,750] [The proposed regulation implementing the 1972 Amendments concerning the calculation of Part B premium rate increases has been adopted and is now reported in place at ¶ 19,654.]

[¶ 26,751] [The proposed Medicaid regulations concerning fraud, previously reported at this paragraph, have been amended and adopted, and are now reported in place at ¶ 21,780.]

¶ 26,752 PERIODIC INTERIM PAYMENTS (PIP)

Part A Intermediary Letter No. 73-37, Sept. 1973.

Provider reimbursement—Periodic interim payments (PIP)—Extension of PIP to SNF's and home health agencies.—Effective September 1, 1973, the

PIP method of reimbursement is available to otherwise qualified SNF's or home health agencies provided: (1) in the case of an SNF, estimated PIP payments for inpatient services will total $25,000 or more a year, or (2) in the case of a home health agency, estimated PIP payments for Part A and B services will either total $25,000 or more a year or will be 50% or more of total allowable costs. The minimum period of payment for SNF's or home health agencies is biweekly. All providers placed on PIP after August 1973 must continue to complete billings in detail. Any current financing outstanding on the date of conversion to PIP must be recovered by offset, at a rate that will achieve full recovery by May 29, 1974, and any PIP payments are subject to the provisions of the 1972 Amendments, effective for cost reporting periods beginning after1972, that limit program payment to the lesser of cost or charges. *Back references:* ¶ 7280-7308, 7355, 24,307.

Provider reimbursement—Periodic interim payments (PIP)—Hospitals converting to PIP after August 1973.—The moratorium placed on hospital conversion to the PIP method on January 29, 1973, is lifted, effective September 1, 1973. However, all hospitals placed on PIP after August 1973 must continue to complete billings in detail (hospitals currently on PIP can continue to use the same billing method), and the minimum period for which PIP payments may be requested by such hospitals is biweekly (hospitals currently on PIP can continue to receive weekly payments). Any current financing outstanding on the date of conversion to PIP must be recovered by offset, at a rate that will achieve full recovery by May 29, 1974, and any PIP payments are subject to the provisions of the 1972 Amendments, effective for cost reporting periods beginning after 1972, that limit program payment to the lesser of cost or charges. *Back references:* ¶ 6420.78, 7280-7308, 7355, 10,193 (§ 3680), 24,307.

[Text of I. L.]

The purpose of this intermediary letter is to furnish interim instructions regarding the Periodic Interim Payment (PIP) method of interim reimbursement for use pending publication of regulations in the FEDERAL REGISTER.

The moratorium placed on conversion of hospitals to the PIP method on January 29, 1973 (see our telegram of that date, regarding suspension of current financing activity, and IL 73-24 [¶ 26,692]) is lifted as of September 1, 1973. In addition, effective September 1, 1973, the PIP method

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is available for skilled nursing facility inpatient services and Part A and Part B home health agency services. The intermediary may approve a provider's request for reimbursement under the PIP method, subject to the qualifying requirements set forth in Provider Reimbursement Manual section 2407 [¶ 7280] and in this letter, effective at the beginning of any month after August 1973, that the intermediary finds to be administratively feasible. However, consistent with the Department's intent in eliminating current financing payments, the following modifications have been made in PIP, effective with the lifting of the moratorium.

Where a provider with current financing outstanding converts to PIP after the lifting of the moratorium, the current financing outstanding on the effective date of the conversion will be recovered by partial offset against the provider's periodic interim payments at a rate that will effectuate full recovery by May 29, 1974. A provider making repayment of current financing on any other basis permitted under the provisions of IL 73-24 must repay any current financing amount outstanding in full prior to conversion to the PIP method of interim reimbursement.

Like hospitals, skilled nursing facilities must have an estimated total Medicare payment for inpatient services of at least $25,000 a year computed under the PIP formula to be eligible for PIP. To qualify for the PIP method, a home health agency must have (1) an estimated total Medicare payment for Part A and Part B services of at least $25,000 a year computed under the PIP formula, or (2) estimated Medicare reimbursement computed under the PIP formula of at least 50 percent of estimated total allowable costs. In addition, the intermediary's approval of the provider's request for PIP reimbursement will be conditioned upon the intermediary's best judgment as to whether payment can be made to the provider under this method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, poor billing practices, etc. Furthermore, the intermediary may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under PIP shows that proper payment cannot be made under this method.

SNFs, like hospitals, are required to submit form SSA-1453 (annotated "still patient" in item 25) and HHAs are required to submit form SSA-1487 (annotated "still receives services" in item 19) for reimbursement under the regular interim payment procedures for services rendered to carryover patients up to the day the provider converts to PIP. In addition, *all providers placed on PIP after August 1973, must continue to complete billings in detail under this method* as under regular interim payment procedures. For hospitals already on PIP, the same provider billing and intermediary bill review procedures now used for PIP purposes will continue to be used until further notice. Intermediaries are expected to monitor Medicare utilization of services in SNFs and HHAs on PIP with special care to assure, in accordance with Provider Reimbursement Manual section 2407.7 [¶ 7308], that current utilization is in line with the estimated utilization used in computing their periodic interim payments. Periodic interim payments to SNFs and HHAs should be recorded as they now are for hospitals on the SSA-1522, Monthly Intermediary Financial Report (see Part A Intermediary Manual, Part 1, section 4314.3), except that the intermediary must first identify the portion of each HHA's periodic interim payment amount applicable to Part A services and the portion applicable to Part B services in order to properly apportion periodic interim payments between the two Medicare trust funds on lines 1(d) and 2(d) and in the "Remarks" section of the SSA-1522.

While payments are usually made at weekly intervals to hospitals already on PIP, payments will be made biweekly to providers electing PIP after August 1973, unless the provider requests a longer fixed interval (not to exceed one month) between payments. The period of services for which such payment is made will be two weeks and the payment will be made two weeks after the end of the period of services to which the payment pertains. The intermediary will compute the provider's periodic interim payment according to the formulae set forth in Provider Reimbursement Manual section 2407ff. and as adapted for HHAs and clarified below.

For example, a provider that requests and is found by the intermediary to qualify for PIP under the criteria set forth in Provider Reimbursement Manual section 2407 and above, may be placed on PIP at the beginning of the first month after August 1973 that the intermediary finds it to be administratively feasible. Assume

that the effective date of the provider's conversion to PIP is September 1, 1973, and that the provider has an $18,000 current financing payment outstanding on September 1. If the provider has elected the minimum biweekly payment cycle, the intermediary may make biweekly payments to the provider beginning on September 28, 1973 (for the two weeks ending September 14). Or, the intermediary may, at its option, make a proportionally reduced initial payment (e. g., 10/14 of the biweekly PIP amount) two weeks after the end of a shorter initial payment period (e. g., on September 24 for the period September 1-10) in order to conform the provider's payment dates to a particular day of the week (e. g., Monday) desired by the intermediary for administrative purposes. Thereafter, payment would be made on the same day of alternate weeks. In either case the intermediary will recover the current financing at the rate of $1,000 from each of the 18 periodic interim payments that would be made to the provider before May 29, 1974.

A provider's reporting period will frequently end during a biweekly payment period. In such cases, the intermediary may make separate payments to the provider for the portion of the payment period falling in the ended reporting period and the portion falling in the new reporting period or may make a single payment to the provider and include information identifying the portions relating to each of the provider's reporting periods.

No changes are to be made in the PIP method for hospitals already on PIP prior to September 1, 1973. Further instructions will be issued regarding prospective changes in PIP for these providers.

The provisions of PL 92-603 limit program payment to the lesser of cost or charges for cost reporting periods beginning after 1972. Payments under PIP are subject to this limitation on the basis stated in Provider Reimbursement Manual section 2406.6 [¶ 7275]—i. e., the average per diem (or per visit) amount used in the PIP formula for calculating estimated total Medicare costs is limited to the lower of the provider's estimated average cost per diem (or per visit) or estimated average per diem (or per visit) charge for covered services for which periodic interim payments are to be made.

Intermediaries are also reminded that, since the initial computation of a provider's periodic interim payment is based upon a projection from its current interim rate, the payment may, like regular interim rates for all providers and recomputed periodic interim payments (see Provider Reimbursement Manual section 2407.5 [¶ 7300]), include an amount reflecting estimated reimbursable Medicare bad debts for the reporting period, based upon the provider's past experience.

Intermediaries should inform all providers of the contents of this letter without delay.

¶ 26,753 HOME HEALTH SERVICES—CUSTOMARY CHARGES—EFFECT OF ECONOMIC STABILIZATION PROGRAM

Cost of Living Council Notice, No. 73-1, 38 F. R. 27236, Oct. 1, 1973. (Notice 73-1 was also transmitted by *Part A Intermediary Letter*, No. 73-47/*Part B Intermediary Letter*, No. 73-41, Nov. 1973.)

Economic stabilization policies—Community health service agencies.—The 1972 Amendments provision requiring Medicare providers to be reimbursed the lesser of "reasonable costs" or "customary charges" will create financial hardship for community health service organizations (visiting nurse associations and home health agencies), which are generally nonprofit and which have historically limited their charges to nominal amounts, because under the Economic Stabilization Program those nominal charges become the "customary charges" against which compliance with the program is measured. The Cost of Living Council has therefore authorized visiting nurse associations and home health agencies to waive the requirements of the stabilization program as it pertains to noninstitutional health providers (6 CFR § 300.19) for the first Medicare reporting period after December 31, 1972, so as to bring their charges for services up to the previous reporting period's cost level for those services. *Back references:* ¶ 7252.83, 24,307.

[Text of Notice]

The Cost of Living Council has determined that as a result of section 233 of the Social Security Amendments of 1972, Public Law 92-603, 86 Stat. 1329, application of the provisions of the economic stabiliza-

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[INTERMEDIARY LETTER 73-24 DATED JUNE, 1973
(CONTAINED IN PARAGRAPH 26,692 OF THE
CCH MEDICARE AND MEDICAID GUIDE)]

Your organization may make medical insurance premium payments either at the $5.80 or $6.30 rate until the ongoing rate is established. Your group liability will be adjusted as soon as possible and your account will be credited with the appropriate amount.

At this time, the only known factor is that the SMIB premium is frozen at $5.80 for July, however, when the ongoing rate is announced, you will be advised promptly.

¶ 26,692 ELIMINATION AND RECOVERY OF MEDICARE CURRENT FINANCING

Part A Intermediary Letter No. 73-24, June 1973; *Supplement*, July 1973.

Payments to providers—Elimination and recovery of current financing.—This Intermediary Letter contains implementing instructions concerning the elimination of the current financing provision from the Medicare principles of reimbursement and the recovery of all amounts paid under that provision and still outstanding on the effective date of the regulations changes—May 29, 1973. The instructions relate to the offset of current financing made prior to May 29, 1973, from equity capital and allowable interest, provider notification requirements, provider requests for an extended recovery period, and intermediary accounting for recovered and unrecovered current financing in reports to SSA. *Back references:* ¶ 5180, 5762, 7354-7386.

Payments to providers—Elimination and recovery of current financing—Effect on accelerated payments.—The applicable requirements of the *Provider Reimbursement Manual* must be met before an accelerated payment can be made. A provider request for an accelerated payment may not be justified by the recision of the current financing regulation nor the recovery of outstanding current financing payments. *Back references:* ¶ 7390, 7394.

Payments to providers—Periodic interim payment (PIP) requests.—The prohibition against the conversion of hospitals to the periodic interim payment (PIP) method of interim reimbursement, which ran to July 1, 1973, under instructions furnished to intermediaries on January 29, 1973, has now been extended beyond that date and until further notice. *Back references:* ¶ 7280-7324.

[Text of I. L.]

General.—On May 29, 1973, the Secretary of HEW promulgated regulations providing for the elimination of the current financing provision from the Medicare principles of reimbursement to health care providers and for the recovery of all amounts paid under that provision and still outstanding as of that date.

The purpose of this letter is to provide the instructions necessary to implement this regulations change.

Effect of regulations change.—The effective date of this regulations change is May 29, 1973. As of that date, current financing payments can no longer be made to providers participating in the Medicare program and all current financing amounts paid to these providers prior to and still outstanding as of that date became overpayments that must be recovered by the program. As explained in the preamble to this regulations change, recovery of these payments is to be accomplished within the 12-month period beginning May 29, 1973, and ending May 28, 1974, except where this period has been extended (see instructions below on extended recovery periods) to avoid the provider experiencing extreme financial hardship. Although this regulations change also removed the reference to current financing in regulations sections 405.429 (b)(2) and 405.419(c)(4), the offset of current financing to equity capital and interest, as previously required by these sections, must still be made for any cost reporting period during which the provider held some or all of its current financing payment.

[The next page is 9277-3.]

Provider notification of regulations change and recovery requirement.—Each provider must be notified immediately, and in writing, of this regulations change by its servicing intermediary. This notice must also inform the provider from which a current financing payment must be recovered as to the amount of its current financing and that full recovery of this amount by May 29, 1974, will be required, unless a longer recovery period is requested and granted. (See the instructions below on extended recovery periods.)

The intermediary's notice concerning recovery of current financing must, in addition, inform the provider whether estimated program payments otherwise due the provider between May 29, 1973, and May 29, 1974, will be sufficient to permit the intermediary to recover the full amount of the provider's current financing by partial offset against these benefits during this 12-month period. Further, this notice must inform the provider that recovery of its current financing by such offset will commence unless, within 15 days of the date of the notice, the provider establishes with the intermediary an alternate recovery schedule. Such an alternate recovery schedule must provide for repayment to commence immediately, result in recovery of at least one-twelfth of the current financing payment each month and result in full recovery of all current financing outstanding by May 29, 1974.

The notice must further advise the provider that a request for an extended recovery period (i.e., a period that exceeds the 12-month period ending May 28, 1974) must be approved by the provider's servicing BHI regional office, as required by section 2228 of the *Part A Intermediary Manual.*

A request for a temporary delay in the commencement of recovery or a schedule of recovery that does not result in repayment of at least one-twelfth of the current financing payment each month on the basis of extreme financial hardship (i.e., circumstances in which recovery would endanger the provider's ability to meet its current obligations as they fall due) should also be referred to the provider's servicing BHI regional office for consideration. The BHI regional office is authorized to approve such exceptions to the general current financing recovery procedure where necessary to the financial solvency of the provider and under circumstances in which there is adequate assurance that the delayed recovery can be effected.

Intermediary accounting for recovered and unrecovered current financing.—Effective June 1, 1973, each intermediary will be expected to maintain a running record of the current financing payments it recovers from the Medicare providers it services, and to report the results of this recovery in the "Remarks" column of Form SSA-1522 (Monthly Intermediary Financial Report) as follows:

OUTSTANDING CURRENT FINANCING PAYMENTS

	Amount	Number Providers
Outstanding—Beginning of Month	$——	——
Amount Recovered—During Month	——	XXXX
Outstanding—End of Month	$——	——

If a provider repays any portion of its current financing by one or more direct refund checks, the checks when received by the intermediary should be deposited in the intermediary's Federal Health Insurance Benefits Account, and the intermediary should reduce its subsequent vouchers of the trust fund to reflect these recoupments.

Intermediaries are also required to bring to the attention of the BHI regional office those providers from which recovery of current financing cannot be made due to special circumstances (e.g., no offset benefits available and the provider declines to refund the payment as directed). These cases should be prepared for referral to the General Accounting Office under the procedures set forth in *Intermediary Manual Part A*—Part 2, section 2234.

Effect of regulations change on update of quarterly provider overpayment report.—The instructions for preparing the Quarterly Provider Overpayment Report state that where an excess current financing amount is not recovered within 90 days from the date of the required recomputation the amount not recovered becomes an overpayment on the 91st day. The regulations change rescinding the current financing provision, however, makes all outstanding current financing amounts overpayments as of May 29, 1973. Since this regulations change becomes effective prior to June 30, 1973, the Quarterly Provider Overpayment

Report instructions on reporting outstanding excess current financing amou.ts should not be followed. All current financing amounts outstanding as of June 30, 1973, must be included in the June 30, 1973, update and subsequent quarterly updates until the outstanding amount has been fully recovered.

Accelerated payment requests.—Each intermediary is hereby cautioned that neither the recision of the current financing regulation nor the recovery of current financing payments made under this regulation are a basis for justifying a provider request for an accelerated payment. The requirements set forth in sections 2412 [¶ 7390] and 2412.1 [¶ 7394] of the *Provider Reimbursement Manual* must be met before an accelerated payment can be approved by the BHI regional office.

Periodic interim payment requests.—Under the instructions furnished to intermediaries on January 29, 1973, conversion of hospitals to the Periodic Interim Payment (PIP)

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method of interim reimbursement was prohibited prior to July 1, 1973. This prohibition must now be extended pending a review of the PIP procedure that is now being conducted. Accordingly, intermediaries are instructed to suspend conversion of hospitals to the PIP method of interim reimbursement until further notice.

¶ 26,693 FIRE SAFETY QUESTIONS AND ANSWERS

Bureau of Health Insurance Letter, State Agency No. 177, June 1973. Subject: "Questions and Answers on Technical Provisions of the Life Safety Code"

Conditions of participation—Fire safety standards.—The Bureau of Health Insurance has received questions and provided answers concerning technical aspects of Medicare and Medicaid fire safety requirements. Several questions concern the requirements for entrances, exits and openings within the building. Other items covered are proper caulking for fire-resistive walls, floors and ceilings; minimum number of fire drills; dampers; smoke detection; building materials and type of construction that conforms to the Life Safety Code. *Back references:* ¶¶ 12,330, 12,380, 14,751, 14,752.

Questions and Answers Relating to the Application of the National Fire Protection Association Life Safety Code to the Medicaid and Medicare Programs

1. Q.—Is the subdivision of patient sleeping floors by smokestop partitions or horizontal exits into two or more compartments or fire sections based upon the cumulative connected corridor length of no more than 150 feet?

A.—No. It is intended that the provision will limit the gross floor area of a compartment as well as the length and width of each compartment on patient sleeping room floors to dimensions not exceeding 150 feet. Such partitions should be so located that travel to a place of refuge such as another smoke compartment or fire section on the same floor, or required exit for each floor or fire section does not exceed 75 feet.

2. Q.—Can a door to any hazardous area be held open by means of electric hold-open devices, equipped with local smoke detection devices?

A.—No. Doors in construction of at least one-hour fire resistance rating enclosing hazardous areas *may not* be held open by any means or device.

3. Q.—Is a labeled 30-minute particleboard core door considered equivalent to a 1¾ inch solid wood bonded core door in a doorway to an institutional sleeping room?

A.—Yes. Any particleboard door that meets ASTM E152-66 Standard Fire Tests of Door Assemblies with a 30-minute fire exposure, plus a 17-second hose stream immediately afterward provides equivalent fire resistance.

4. Q.—Are rated door frame assemblies required in the door openings to patients' rooms?

A.—No. A 1¾ inch solid cord wood door is not a fire door and does not require a rated frame. .

5. Q.—Are doors to patient sleeping rooms provided with friction roller latches acceptable?

A.—Yes. A 1¾ inch solid core wood door is *not a fire door* and does not need closers and positive latching devices required by rated fire door assemblies.

6. Q.—Do the requirements for firestopping concealed spaces in new construction apply to existing buildings?

A.—No. (See 6-1311 for new buildings.) The provisions for firestopping in existing buildings are set forth in 10-2323. As a related requirement of subdividing floor areas the provisions of 10-2323 do, however, require that the smoke barrier ". . . be continuous from wall to wall and floor to floor or roof arch above," thereby achieving some horizontal firestopping in the concealed spaces.

7. Q.—When doors in horizontal exits and smokestop partitions are held open by electric hold-open devices which comply with 5-2134, which method(s) must be provided for current interruption of the door hold-open devices in existing buildings?

Opinion and Order of Judge Metzner Permitting Intervention

U.S. District Court
Filed
Dec 4 1975
S. D. of N. Y.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION, et al.,

Plaintiffs,

-against-

DAVID MATTHEWS, et al.,

Defendants.

75 Civ. 5902

#43472

METZNER, D. J.

The application for intervention in the above action on behalf of those plaintiffs set forth in the proposed complaint is granted. The determination of the motion for a preliminary injunction in which evidence was taken on November 29, 1975, will be binding on the intervenors without further evidence being adduced.

I will assume that the pattern as developed on the evidenciary hearing concerning the original plaintiffs would be the same for the intervenors if proof was submitted on their behalf.

So ordered.

Dated: New York, New York
December 3, 1075

CHARLES M. METZNER
U. S. D. J.

Order to Show Cause of Intervenor Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,	ORDER TO SHOW CAUSE WITH TEMPORARY RESTRAINING ORDER
Plaintiffs,	75 CIV. 5902
-against-	CMM
DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,	
Defendants	

Upon the affidavit of Andrew Ross sworn to the 3rd day of December, 1975, upon the certification of notice of Andrew Ross and upon all proceedings had herein, and good cause appearing therefor, it is hereby

ORDERED that defendants, their officers, agents, servants, employees and attorneys appear before this Court in Room of the United States Courthouse, Foley Square, New York, New York, on the day of December, 1975, at o'clock in the noon of that day, or as soon thereafter as counsel can be heard to show cause why an order should not be entered: (a) granting movants' motion to intervene in the within action as plaintiffs pursuant to Rule 24 of the Federal Rules of Civil Procedure; and (b) granting movants a preliminary injunction

pursuant to Rule 65 of the Federal Rules of Civil Procedure pending final determination of this action restraining defendants and their officers, agents, servants, employees and attorneys from applying, or attempting to apply the newly promulgated Period Interim Payments regulation for Medicare reimbursement contained in 20 CFR Sec. 405. 454(j) to the movants, and it further appearing to the Court from the pleadings attached hereto that a temporary restraining order preliminary to the hearing upon movants' motion for a preliminary injunction should issue because of the proposed unlawful application of the regulation; that defendants unless enjoined threaten to enforce this regulation; that the application of the regulation to movants will likely occur prior to said hearing date unless restrained by an order of this Court; that the application of the regulation to movants will cause them immediate and irreparable injury before the hearing can be held on the motion to intervene and for a preliminary injunction in that it will seriously and permanently impair the ability of movants to render hospital and health services to the public; and movants having made no previous application for the relief requested herein, it is hereby

ORDERED, that for a period not to exceed ten days after the entry of this order or until the day of December, 1975 at o'clock in the noon or as soon thereafter as counsel can be heard, unless this order be dissolved prior thereto or extended then or thereafter whichever is sooner,

Defendants, their officers, agents, servants, employees and attorneys be and hereby are temporarily enjoined and restrained pending the hearing and determination of this motion, from applying or attempting to apply, the newly promulgated Periodic Interim Payments reimbursement regulation contained in 20 CFR Sec.405.454(j) to the movants; and it is further

ORDERED THAT SECURITY AS REQUIRED BY FRCP 65(c) BE WAIVED, and it is further

ORDERED that personal service of this order to show cause and temporary restraining order together with a copy of the papers upon which it is based upon the United States Attorney for the Southern District of New York and upon Proskauer, Rose, Goetz & Mendelsohn, 300 Park Avenue, New York, New York if made on or before o'clock in the noon of the day of December, 1975, shall be deemed sufficient service thereof.

Dated: Great Neck, New York
December 3, 1975

Issued at
p.m.

United States District Judge

Affidavit of Andrew Ross in Support of Application for Intervention

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants.

AFFIDAVIT

75 Civ. 5902
CMM

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STATE OF NEW YORK)
) SS.:
COUNTY OF NASSAU)

ANDREW ROSS, being duly sworn, deposes and says:

I. I am a member of the bar of this Court and am associated with the firm of Hayt, Hayt, Tolmach & Landau, attorneys for all the hospitals which, by this motion, seek to intervene in the instant action (hereinafter referred to as either "Movants" or the "Hospitals"). I am familiar with all the facts recited herein, and I make this affidavit in support of the Hospitals' motion for an order: (a) pursuant to Rule 24 of the Federal Rules of Civil Procedure permitting the Hospitals to intervene as plaintiffs herein and (b) pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining defendants, their officers, agents, servants, employees and attorneys, pending final determination of this action from implementing or attempting to implement,

as to the Movants, newly promulgated Periodic Interim Payments regulation for Medicare Reimbursement contained in 20 CFR 405.454(j) (hereinafter referred to as "PIP").

2. On or about November 21, 1975 this Court entered an interlocutory order in this action restraining defendants from implementing any changes in existing PIP regulations with respect to the reimbursement of hospitals for the care they render to Medicare patients.

3. After that order was issued, both we and the Hospitals we represent assumed that the government would not implement new PIP regulations at all until a final determination of this action.

4. Indeed, Movants anticipated they would continue to receive Medicare reimbursement as they have since 1968, on a weekly basis, at least until this Court ordered otherwise. As a matter of fact, since the preliminary restraining order was entered herein nearly two weeks ago, the government made no public announcement of its intention to unilaterally limit the force and effect of this Court's order so as to render it null and void with respect to Movants*, all of which are voluntary or not-for-profit hospitals similarly situated with plaintiffs, though not members of the Greater New York Hospital Association.

5. We learned last night that the government intended to implement the new PIP regulations to hospitals in this State which are not parties to this action.

6. We cannot believe that this Court's order restraining defendants' implementation of new PIP regulations is effective only insofar as that regulation affects the member hospitals of

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*Surely if the injunction that issued were final, the government could not argue that the challenged regulation was, nonetheless, applicable as to hospitals not named as plaintiffs.

the Greater New York Hospital Association. Defendants should not be permitted to sterilize an order of this Court simply because the class purported to be represented by plaintiffs has been defined so narrowly as to exclude virtually every hospital outside New York City. Due process and equal protection forbid defendants' application of different rules of law, based solely on membership in a voluntary association, to determine payment rates and schedules to hospitals under Medicare.

7. Defendants' furtive attempt to implement the new PIP regulation should not be permitted to succeed. Movants anticipated a December 1st PIP payment. Many of the hospitals need this payment to meet payrolls -- they simply did not attempt to secure or locate other sources of funds because they believed that the prior order of this Court was fully binding on defendants.

8. A denial of this motion to intervene will impair and impede Movants' right to protect their interests which are identical to those of the named plaintiffs. (A copy of Movants' proposed pleading is annexed hereto as Exhibit "A").

9. No prior application for the relief herein sought has been made by Movants.

Andrew Ross
ANDREW ROSS

Sworn to before me this
3d day of December, 1975.

George Colman
Notary Public

GEORGE COLMAN
Notary Public, State of New York
No. 41-5707281 - Queens Co.
Term Expires March 30, 1976

Certification of Andrew Ross in Support of Application for Intervention

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968, Plaintiffs, -against- DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security, Defendants.	CERTIFICATION 75 Civ. 5902 CMM

I, ANDREW ROSS, am an attorney duly admitted to the bar of this Court. I hereby certify pursuant to the local Rules of this Court that at approximately 1 p.m., I spoke with attorneys for Plaintiff, particularly Susan Rosenfeld and at approximately 1:45 p.m., I spoke to the attorney for Defendants, Frederick Schaffer and I informed both of them that at 3:30 p.m. I would be making an application to this Court to intervene in the captioned action and to request an Order restraining Defendants from implementing the new PIP regulation as to the hospitals on whose behalf the application is made.

Andrew Ross

Proposed Complaint in Support of Application for Intervention

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, JOHN T. MATHER MEMORIAL HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, and EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS, CENTRAL SUFFOLK HOSPITAL ASSOCIATION

Plaintiffs,

-against-

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants.

----------x

PROPOSED COMPLAINT

75 Civ. 5902
CMM

Plaintiffs, by their attorneys, Hayt, Hayt, Tolmach & Landau, for their complaint, allege:

1. Plaintiffs are voluntary not-for-profit hospitals duly organized and existing pursuant to the laws of the State of New York rendering hospital and health related services to, among others, patients covered by the Medicare Act (42 U.S.C. section 1395 et seq.). Plaintiffs are located in the various counties of the State of New York, including the counties of Westchester, Putnam, Sullivan and Dutchess in this district.

EXHIBIT "A"

2. Defendant, David Matthews, is the Secretary of the Department of Health, Education, and Welfare and is sued herein in that capacity.

3. Defendant, James B. Cardwell, is the Commissioner of Social Security and is sued herein in that capacity.

4. This Court has jurisdiction over this action for an injunction and declaratory judgment pursuant to 28 U.S.C. sections 1331, 1361, and 2201.

5. Venue lies in this district pursuant to 28 U.S.C. section 1391.

6. Pursuant to Rule 10(c) of the Federal Rules of Civil Procedure, plaintiffs hereby adopt by reference all the allegations contained in the complaint filed herein by and on behalf of Greater New York Hospital Association on November 21, 1975 with the same force and effect as if said allegations were fully set forth at length herein.

WHEREFORE, plaintiffs pray for a judgment: (a) permanently enjoining defendants, their officers, agents, employees and attorneys from implementing or attempting to implement the newly promulgated Periodic Interim Payments regulation for Medicare reimbursement contained in 20 C.F.R. 405.454(j); (b) declaring said regulation null and void; and (c) such other and further relief as the Court deems just and proper.

Yours, etc.

Hayt, Hayt, Tolmach & Landau

By _____
Andrew Ross
Attorneys for Plaintiffs
Office & P.O. Address
55 Northern Boulevard
Great Neck, New York 11021
(516) 466-5800

Opinion and Order of Judge Metzner
Dismissing Complaint

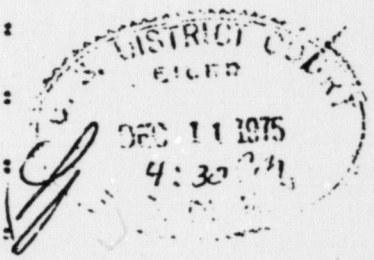
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

- -x

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs,

#43521



UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHILIPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs,

-against-

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants.

75 Civ. 5902 (CMM)

- -x

A P P E A R A N C E S

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Frederick P. Schaffer
Taggart Adams
Assistant U.S. Attorneys
Of Counsel

METZNER, D. J.:

The original plaintiffs, composed of the Greater New York Hospital Association (GNYHA) and Peninsula Hospital Center, on behalf of themselves and other voluntary nonprofit hospitals which are members of GNYHA, move for a preliminary injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure. They seek to enjoin the Secretary of the Department of Health, Education and Welfare (HEW) and the Commissioner of Social Security from implementing a promulgated regulation changing the mode of reimbursement for Medicare services rendered. 20 C.F.R. § 405.454(j), 40 Fed. Reg. 29815 (July 16, 1975). After the close of the evidentiary hearing held on the motion, 25 other voluntary nonprofit hospitals applied for and were granted permission to intervene in the proceedings.

All parties have now informed the court that pursuant to Fed. R. Civ. P. Rule 65(a)(2), they consent to advancing the trial of the action on the merits and consolidating it with the hearing of the application.

In order to understand fully the nature of the problem here presented, it is necessary to review the

method of Medicare reimbursement in some detail.

When Medicare was first instituted in 1966, interim payment was made upon presentation of patient bills to the Medicare intermediaries (insurers in their own right who were designated by the government as its agents to approve and make Medicare payments on the local level). Within two years thereafter, huge time lags in presentation of bills and resulting payments had arisen, causing serious cash flow problems in the hospitals (called "providers" by the Medicare Act).

Accordingly, in 1968, in an attempt to alleviate this burden, the Commissioner instituted a Periodic Interim Payment plan (PIP). Under this arrangement, an average annual Medicare payment for each provider is determined in advance. That amount is then divided into 52 parts and paid weekly to the provider regardless of services actually performed. At the end of the year, an annual report of detailed costs is presented by the provider, and adjusted against payments made to reflect the actual Medicare reimbursement. Only 300 hospitals out of 6,700 hospitals in the Medicare program had elected to receive PIP reimbursement, when in January

1973, HEW placed a freeze on any additional PIP participants while it evaluated the system. All plaintiff hospitals are currently reimbursed by this system.

It was determined in 1973 that the PIP plan paid some hospitals in advance of rendering medical care. A new Periodic Interim Payment plan was instituted, providing for biweekly payments which covered estimated services rendered in the third and fourth preceding weeks (New PIP). Under PIP the average lag in payment for services rendered is 3-1/2 days, while it is 21 days under New PIP. Providers under PIP at the time were allowed to continue under that system or transfer to New PIP. All new entrants to the system could only come in under New PIP. 500 hospitals have availed themselves of New PIP.

To sum up, the vast majority of participating hospitals are being paid under the original plan of interim payments against submission of patient bills. Somewhat less than 300 are being paid under old PIP and some 600 are being paid under New PIP.

On January 16, 1974, a Notice of Proposed Rule Making was published announcing a proposed amendment to the old PIP system whereby old PIP providers would be converted to New PIP, 39 Fed. Reg. 2011, and on July 16, 1975, the regulation was promulgated, 40 Fed. Reg. 29815, effective September 15,1975. Through an amendment, the effective date of implementation was extended to December 1, 1975.

Under the plan of implementation, all old PIP providers were to miss the payment scheduled for December 1, 1975 and receive two weeks' payment on December 8, and thereafter biweekly. Starting with the payment of December 22, 1975, they were to receive a percentage less than the full amount so that by May 24, 1976, there would be an average 21-day lag, with bi-weekly payment.

Plaintiffs claim that the regulation was promulgated arbitrarily, capriciously, without a sufficient statement of reasons, and was an abuse of discretion on the part of the defendants. They further argue that the regulation is not in accordance with law in that it violates the Medicare Act and regulations

promulgated thereunder.

Defendants contend that the regulation is not subject to judicial review and that in any case, it is neither arbitrary nor capricious, has sufficient statement of reasons, and is in accordance with the Medicare Act and regulations.

In the instant case, 42 U.S.C. § 1395g provides in pertinent part:

> "The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) . . . ." (Emphasis added.)

In Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971), the Supreme Court set forth the criteria under which judicial review of agency action is proper under the Administrative Procedure Act. 5 U.S.C. § 701. The Court stated that agency action is "subject to judicial review except where there is a statutory prohibition on review or where 'agency action is committed to agency discretion by law.'" Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. at 410.

In the instant case, there is no clear and convincing showing of a legislative intent to prohibit judicial review. Accordingly, only if the agency action represented by the regulation is "committed to agency discretion by law" is review barred. This is "a very narrow exception," and is applicable "in those rare instances where 'statutes are drawn in such broad terms that in a given case there is no law to apply.'" Id.

In Overton Park, the statute in question provided that the Secretary of the Department of Transportation shall not approve any program or project that requires the use of any public parkland, "unless (1) there is no feasible and prudent alternative to the use of such land . . . ." 23 U.S.C. § 138.

The Court rejected the argument that the words "feasible" and "prudent" gave the Secretary unfettered discretion making judicial review impermissible under Section 701. It found that Congress, obviously, was making the preservation of parkland paramount, and that the Secretary could not approve the destruction of parkland unless he found that alternative routes presented unique problems. Thus, the Court concluded that there

was "law to apply" to the Secretary's determination to take parkland, and the narrow exception of agency discretion did not exist.

Turning to the instant case, the wording of Section 1395q makes clear that the period of time within which payment is to be made is "at such time or times as the Secretary believes appropriate," but not less often than monthly. There is no dispute that the New PIP payments are to be made within the period of one month.

A review of the legislative history of the Act does not reveal any congressional interest in the question of payment, aside from the statutory provision that it be made at least monthly. The fixing of the payment dates within that period is committed to agency discretion by the statute and there is no "law to apply." Judicial review is barred by Section 701.

Plaintiffs urge that there is "law to apply" because the agency has adopted a regulation providing that "intermediaries are expected to make payments on the most expeditious basis administratively feasible." 20 C.F.R. § 405.454(b).

It seems clear, both from testimony adduced at the evidentiary hearing and from a close study of the Medicare regulations as originally promulgated, that this regulation was adopted on November 22, 1966 in conjunction with the original form of interim payments. There is no evidence that the concept of "most expeditious payment administratively feasible" in any way was a matter of congressional intent, or anything more than what the Secretary believed to be appropriate in the case of bill submissions. Accordingly, this regulation is not a standard applicable to the regulation under attack here.

Finally, plaintiffs argue that the regulation was improperly promulgated because of an insufficient statement of reasons in the regulation itself. Assuming, arguendo, that the Secretary was required to publish reasons, whether under the APA or by undertaking to do so, and that such reasons were insufficient as published, such reasons are properly supplemented by hearing, as was done in this case. National Nutritional Foods Association v. Weinberger, 512 F.2d 688 (2d Cir. 1975).

The promulgation of this regulation in July 1975 stated that "careful consideration of the introduction of an average 3-week payment lag into the PIP method demonstrated that such a lag compares favorably with the average lag in payment experienced by providers reimbursed under regular interim payment procedures." 40 Fed. Reg. 29816. This is an adequate reason for the government putting off its obligation of payment. In addition, the government's witness testified that under old PIP the weekly payments were going to the hospitals long before the latter were paying their vendors. Finally, stretching out the payments within the permissible period was accruing interest for the benefit of the Medicare fund.

Plaintiffs urge that the 17-1/2 day extension of payment lag (from an average of 3-1/2 days to 21 days) places undue harsh financial burdens on the presently precarious position of the objecting hospitals. Some hospitals would have to borrow money for cash flow purposes incurring [illegible] interest costs. According to the stipulation submitted on the hearing, the borrowing would amount to a permanent figure of

nearly $30 million for all the plaintiffs. Some hospitals could not obtain additional loans for this purpose because of the existing level of their indebtedness. It appears that about one-third of the average hospital's income is derived from Medicare payments.

I have no doubt that these facts are in the main true, but they have no bearing on the instant lawsuit. They must await determination by the government as to the amount of reimbursement that will be made to the hospitals for the added interest cost.

Similarly, the resolution of the question of whether Medicare costs will be transferred to non-Medicare patients must await the determination of the amount of reimbursement. It should be noted that the regulation under attack does not deal with this problem.

The complaint is dismissed.

So ordered.

Dated: New York, N.Y.
December 11, 1975

U. S. D. J.

Order Granting Stay of Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,	
Plaintiffs,	
UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,	75 Civ. 5902 (CMM)
Intervenor Plaintiffs,	ORDER GRANTING STAY OF JUDGMENT
- against -	
DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,	
Defendants.	

Plaintiffs having moved this Court for ~~an injunction~~ a stay pending appeal, and it appearing to the Court that it is necessary that ~~an injunction~~ a stay be granted until such time as plaintiffs are heard by the United States Court of Appeals for the Second Circuit on their motion for an

injunction pending appeal on the grounds that they will suffer irreparable injury if defendants change the manner of reimbursing the plaintiffs from the present Periodic Interim Payment system to the new Periodic Interim Payment system as set forth in 20 C.F.R. 405.454(j) and Part A Intermediary Letter No. 75-58 of October, 1975, it is hereby

ORDERED, that until December 23, 1975, defendants, their officers, agents, servants, employees and attorneys are restrained from applying and attempting to apply the newly promulgated Periodic Interim Payment Reimbursement Regulation contained in 20 C.F.R. Section 405.454(j) to the plaintiffs or the members of the Class herein or to the Plaintiffs-Intervenors.

Dated: New York, New York
December 12, 1975

/s/ Charles M. Metzner
UNITED STATES DISTRICT JUDGE

Plaintiffs' Notice of Appeal

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,	
Plaintiffs,	
UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,	75 Civ. 5902 (CMM) NOTICE OF APPEAL
Intervenor Plaintiffs,	
-against-	
DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,	
Defendants.	

Notice is hereby given that plaintiffs Greater New York Hospital Association and Peninsula Hospital Center, on behalf of themselves and all other voluntary nonprofit hospitals which are members of Greater New York Hospital Association and which are reimbursed for Medicare

services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968, hereby appeal to the United States Court of Appeals for the Second Circuit from the order and judgment entered in this action by the United States District Court for the Southern District of New York on December 11, 1975, dismissing their complaint.

Dated: New York, New York
December 12, 1975.

PROSKAUER ROSE GOETZ & MENDELSOHN
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022

By _____
A Member of the Firm

To:

THOMAS J. CAHILL, Esq.
United States Attorney
for the Southern District
of New York
Attorney for Defendants
1 St. Andrews Plaza
New York, New York

HAYT, HAYT, TOLMACH & LANDAU, Esqs.
Attorneys for Plaintiffs-Intervenors
55 Northern Blvd.
Great Neck, N.Y. 11021

Plaintiffs' Bond for Costs on Appeal

THE ÆTNA CASUALTY AND SURETY COMPANY
Hartford, Connecticut 06115

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs,

-against-

DAVID MATHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as UNITED STATES COMMISSIONER OF SOCIAL SECURITY,

Defendants.

Notice is hereby given that plaintiffs Greater New York Hospital Association and Peninsula Hospital Center, on behalf of themselves and all other voluntary nonprofit hospitals which are members of Greater New York Hospital Association and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968, hereby appeal to the United States Court of Appeals for the Second Circuit from the order and judgment entered in this action by the United States District Court for the Southern District of New York on December 11, 1975, dismissing their complaint.

NOW, THEREFORE, THE ÆTNA CASUALTY AND SURETY COMPANY, of Hartford, Connecticut, a corporation duly authorized to transact business in the State of New York, and having an office and usual place of business at 200 East 42nd Street, New York, State of New York, does hereby, pursuant to the Statute in such case made and provided, undertake, that the appellant Greater New York Hospital Association and Peninsula Hospital Center et al will pay all costs and damages which may be awarded against said appellant on said appeal not exceeding Two Hundred Fifty Dollars.

Dated, December 15, 1975.

THE ÆTNA CASUALTY AND SURETY COMPANY

BY: _____
A. Brennan, Attorney in Fact

Notice of Appeal of Intervenor Plaintiffs

Served _____

Received Mail 12/19/75

Entered in Docket 12

Entered in Diary For _____

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs,

-against-

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants.

75 Civ. 5902 (CMM)

NOTICE OF APPEAL

Notice is hereby given that Intervenor Plaintiffs all of which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968, hereby appeal to the United States Court of Appeals for

the Second Circuit from the order and judgment entered in this action by the United States District Court for the Southern District of New York on December 11, 1975, dismissing their complaint.

Dated: Great Neck, New York
December 18, 1975

HAYT, HAYT, TOLMACH & LANDAU
Attorneys for Plaintiffs-Intervenors
55 Northern Boulevard
Great Neck, New York 11021

By _____
A Member of the Firm

To:

THOMAS J. CAHILL, Esq.
United States Attorney
for the Southern District
of New York
Attorney for Defendants
1 St. Andrews Plaza
New York, New York

PROSKAUER ROSE GOETZ & MENDELSOHN
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022

Stipulation Designating Exhibits

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs,

-against-

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants.

75 Civ. 5902 (CMM)

STIPULATION

IT IS HEREBY STIPULATED AND AGREED, by and between the undersigned, that plaintiffs' Exhibits 1 and 2 introduced into evidence at the hearing held in this matter on November 28, 1975 before Judge Charles M. Metzner are hereby

made part of the record on appeal.

Dated: New York, New York
December 19, 1975

PROSKAUER ROSE GOETZ & MENDELSOHN
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022

By _____
A Member of the Firm

Thomas J. Cahill
United States Attorney for the
Southern District of New York
Attorney for Defendants

By _____
Frederick P. Schaffer
Assistant U. S. Attorney
1 St. Andrews Plaza
New York, New York
791-1973

COPY RECEIVED Gabriel
Thomas J. [redacted]
UNITED STATES ATTORNEY
1-9-76.

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